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Two Inspirations

A Canadian novelist has just published a notable contribution to our understanding of life in this our Province of Quebec, in a book called "The Two Solitudes". We might call this short essay "Two Inspirations".

This past year I spent a few days in a very old hospital, situated high on the banks of the beautiful Saguenay River. It faces up the river and, because of this, also faces the gorgeous sunsets seen in this part of Quebec. The Sisters, whose responsibility this hospital is, were delightful hostesses, garbed in their old world habits, moving about in a quiet serene way, and showing their eager desire to know what nurses did who were out in the world, and what they could do to make their own beloved "Hotel Dieu" as perfect as possible.

I came away wondering whether we, who were out in the world, full of the knowledge of modern nursing educational methods, fully appreciated the contribution and the value of having in our midst and permeating our profession, this strong force of vocational devotion to duty. Two days later I was present at the graduation exercises of a large class of young lay nurses in an old

Rice, Montreal

Eileen Flanagan

established training school famous for the forceful personality of its founder. Here one saw the other side of our heritage in this Province — the English lay nurse, imbued, too, with a sense of vocation, but a little farther away, a little more exposed to the worldly demands of the profession. I thought of the two streams flowing together, making between them the "guardians of the sick", and the bearers of the flag of Public Health.

Situations which are different, which are out of the ordinary, which require especial attention to make them work are always interesting and challenging since they call for ingenuity, forbearance, imagination and flexibility. We in the Province of Quebec are always conscious of the "out of the ordinary aspect" of our duties and privileges. The fact that we have two languages to work with, two sets of racial characteristics to balance, of necessity makes for diversity of expression, and a wider range of ideas and thought.

Since the great majority of our training schools are administered by the Sisters of Religious Orders, we have the older strong religious vocational impulse added to the modern educational methods and outlook, and if we have the will and the vision we have the opportunity to be saved from the perhaps too materialistic and mundane influences which affect those less favourably situated.

We know that very powerful searchlights are focussed on nurses and nursing at this very moment, and we know that while we draw considerable commendation, we also draw a fair amount of criticism. Actually it is because so much is expected of the profession, because the public conjure up a combination of a "Saint", a "Nightingale", a highly trained technician, and a beautiful lady, that unfortunately they are sometimes sadly disappointed.

The wonder is that there are so many who do satisfy most of these requirements! With the great examples of leaders of two nationalities, two languages, two branches of religion, and two ways of life to inspire us, we in this Province should be able to produce the ideal nurse. This year we are celebrating the twenty-fifth anniversary of organized nursing, twenty-five years of effort on the part of these leaders to assure nursing its proper place in our regime. It is a matter of great importance, both professionally and nationally, that several thousands of nurses of two languages are working together in one official organization to promote the health of the citizens and to show that it is possible to reconcile differences for the good of all.

EILEEN FLANAGAN
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Preview

One of the knottiest problems in the school of nursing today is how to provide for experience and training in tuberculosis nursing. Our sanatoria are frantically calling for graduate staff, yet in so many instances nurses have had no actual experience with this disease and are beset with an unwarranted fear of it. How one province has solved the problem of providing undergraduate training in tuberculosis is described in detail by Ferne Trout, instructress with the Division of Tuberculosis Control in British Columbia.

Summer camping days will soon be with us again and in many communities a search will be underway for a nurse who will be free to go to camp to care for the health and general well-being of the hordes of children. Lilian MacKinnon had a pleasant though busy time in such a place last summer. Watch for her story of her experiences.

Puerperal Care and Some Complications

WILLIAM J. STEVENS, M.D.

The puerperium begins as soon as delivery has taken place and lasts until the body has returned to normal or as near the normal state as possible. It may be divided into three periods: (1) Immediate—to cover the time the mother remains in the delivery room; (2) intermediate — the time she is confined to the hospital or home; (3) late — to extend over a year if necessary following the birth of the child.

IMMEDIATE PUERPERAL CARE:

Prophylactic, thorough antepartum care should ensure that the patient will be well able to withstand the birth. Generally speaking, ergometrin .5 mg. or some other uterine stimulant is given after complete placental separation and expulsion. The patient is covered with warmed blankets. The fundus should be held firmly but not massaged until it is well contracted down, its contents all expelled and the nurse is sure that there is no abnormal bleeding. It is much better for the patient to retain her own blood than to have to resort to transfusion.

Postpartum hemorrhage, besides threatening a woman's life, also prolongs her recovery. The average blood loss should not exceed 300 cc. Excessive loss, which constitutes postpartum hemorrhage, may be caused by (1) uterine atony or loss of muscular contractile power or tone, due to many pregnancies or the weakening of the muscles from a disease such as tuberculosis, cardiorenal conditions, anemia, fibroids, etc.; (2) retention of a piece of placenta, membranes or blood clots; (3) too rapid or forcible Crede expulsion of the placenta; (4) trauma from instrumental interference, manual manipulations or rupture of the uterus; (5) prolonged use or over-dose of anesthesia or analgesia; (6) distended bladder, which of course should have been completely emptied by catheter; (7) cervical laceration.

In the event of hemorrhage, immediate adequate nursing and medical treatment must be resorted to and it is here that a well-equipped hospital, with live-wire nurses, may mean the difference between life and death. The patient is covered with warmed blankets, pituitrin or ergot may be given, oxygen, stimulants, a sedative like morphine, Trendelenburg position, the uterus may be packed, followed by intravenous glucose or warm saline, pending blood transfusion, (or blood plasma to combat shock). Cervical laceration requires immediate suture. Rupture of the uterus may demand hysterectomy.

Asphyxia Neonatorum: There are two types of asphyxia: (1) livid-cyanotic or bluish; (2) pallid-pale (more serious).

Causes: Atelectasis pulmonum (if the alveoli in a part of the lung do not expand). In the initiation of respiratory movements in utero asphyxia may result by the aspiration of amniotic fluid, mucus or meconium, thus blocking the air passages. This accounts for some inexplicable deaths, at or shortly after birth, where everything seemed to be normal. Such babies, if they survive, are very likely to develop pneumonia later. Anything which interferes with the blood flow from the placenta to the baby, such as compression on the cord from the baby's head in a breech, a prolapsed cord, knots in the cord, the cord being tightly wound around the baby's head or body, or from premature placental separation. Sometimes the head is compressed too long in the vagina in a too tardy delivery resulting in pressure on the brain; overdose of sedative drugs, like the barbiturates or morphine, and especially if too much anesthesia like ether is given after these analgesics.

Asphyxia may be anticipated in a strenuous, prolonged or abnormal labour; in cases where the fetal heart is very rapid — over 150, or very slow—below 100; where meconium is passed, except in breech presentation; where there are tumultuous movements of the fetus.

Treatments: Where anticipated, the nurse should have everything ready for resuscitation. The baby is delivered speedily and the cord tied at once. After clearing the mouth of mucus, the proper measures must be taken immediately as every second counts:

1. Vitamin K is given by hypodermic.

2. Foreign matter is removed from the air passage. The baby is held up by its feet, the throat is cleared of mucus by suction with a tracheal catheter. The buttocks are slapped gently, the baby is rubbed along its spine or sprinkled with cold water.

3. Mouth-to-mouth insufflation is sometimes used. The nurse places a fold of sterile gauze over the baby's mouth, the doctor then, mouth-to-mouth, blows gently into the baby's mouth to distend the lungs. In this way, mucus is forced out through the baby's nose and wiped away by the nurse. The carbon dioxide from the breath stimulates respiration. This may be repeated in conjunction with hot and cold tubs and Sylvester's method.

4. A mixture of pure oxygen or oxygen and carbon dioxide (7 per cent) from a cylinder may be given by inhalation or by intratracheal suction and insufflation, but the human breath is always available and saves a great deal of time. Later the baby may be put in an oxygen tent.

5. Hot and cold baths. Submerge the baby, all but the head, alternately in a tub of warm water at 110 degrees and in a cold one at 70 degrees. The baby may be sprinkled with cold water while in the warm tub.

6. Sylvester method of resuscitation may be resorted to by raising the baby's arms gently above its head and then compressing them on the chest.

7. Stimulants, such as Lobeline, Coramine, Adrenalin may be given.

So long as the heart beats, never give up. Sometimes after an hour's work the infant will breathe and success here is very gratifying. You have saved a life.

THE INTERMEDIATE POSTPARTUM CARE WHILE IN HOSPITAL:

Height of the Fundus: Immediately after the baby is born, the fundus is usually on a level with the umbilicus. The uterus normally contracts and retracts down (called involution) about one finger-width per day; by the tenth day it is generally in the pelvis and is not felt above the pubes. The blood vessels are constricted by the contraction and retraction of the muscles. The nurse charts daily the height of the fundus and always makes special note if the fundus is too high (called subinvolution) which is nearly always associated with bloody lochia and is weakening to the patient.

Subinvolution is where the uterus fails to contract down to normal size after delivery. Persistence of bleeding after delivery is usually due to the fact that the proper contraction and retraction of the uterus is interfered with, either by poorly developed or weakened muscles, by the retention of placenta or membranes, by infection or by a full bladder.

In the treatment of subinvolution the nurse may massage the uterus to aid in the expulsion of anything retained and apply an icebag on the fundus. In all cases of faulty drainage raise the head of the bed — put the mother in the Fowler position so as to increase drainage. Activate the bowels, give nourishing food and a tonic, and encourage the patient to move about in bed. Patients may be given ergot hypodermically or by mouth. Ensure no bladder distension.

Lochia is the natural bloody discharge after childbirth. It acts as a guide in the puerperium. It is discharged for from two to three weeks after delivery. For the first three or four days it is red, bloody, with decidual and epithelial cells and has a characteristic odor; for the next three or four days, it is brown and watery; for from seven to fourteen days it is pale and watery. Red lochia persists longer in elderly primipara and in women who do not nurse their babies.

There is danger ahead when the lochia stops suddenly and when it is foul-odored. It may be due to subinvolution, retained placenta or membranes, to stenosis, closure of the external os which may be followed by localized infection in the uterus, called sapremia, or a generalized blood infection called septicemia. Hemorrhage is possible too. The nurse always charts the amount and character of the lochia, whether bloody or purulent and if any odor is noticeable.

After-pains are rare with the first baby. These painful uterine contractions probably are due to the accumulation of blood clots and the loss or diminution of uterine contractile power or tone. They are especially common in multipara when nursing, after taking ergot, or in overdistended uteri after twins, hydramnious or protracted labours. They disappear usually after the third day. A sedative, ice bag to fundus, with massage or medicine to aid uterine contraction will relieve this discomfort.

Bladder and Catheterizing: The bladder sometimes gets greatly distended during labour. Always watch for a rounded prominence over the pubes, which is a full bladder requiring catheterizing. The patient should void soon after labour. If she does not, induce it by all known methods, such as applying a hot water bottle over the pubes, letting tap water run, pouring water, sometimes over the vulva, giving a warm bed pan, letting patient sit up or even stand on the floor at the bedside. Catheterize every eight hours if necessary, using careful standard technique. Before delivery a full bladder greatly retards the downward descent of the head. After delivery, it may cause hemorrhage, retroversion, and great discomfort. It is the nurse's duty to report a distended bladder or failure to void. Long labours, difficult deliveries and excessive anesthesia cause fatigue which interferes with natural voiding.

Diet: First day, fluids; second day, soft diet; third day, etc., full diet where normal. There is nothing which produces an appreciable influence on either the quality or quantity of breast milk. Foods which have been recommended for this purpose have no demonstrable influence.

A daily sponge bath is given. Temperature, pulse and respirations are taken every four hours. The room should be kept bright and airy.

In normal cases, the bowels are moved with daily dosage of liquid petrolatum, an enema or a gentle purgative. Constipation, if marked, may be responsible for a rise in temperature. Where we have a repaired perineum or an episiotomy, give all treatments very carefully. An enema is preferable to a laxative, as a loose stool is liable to infect the wound. An antiseptic pitcher douche is given after each urination and bowel movement and every four hours, with careful replacement of sterile pad to vulva.

After a third degree tear (to the rectum) the bowels are rendered inactive with medicine so as to permit the torn, separated ends of the sphincter ani to grow together again and to prevent infection from feces. No catharsis or enemata are given. Diet is restricted to fluids or non-residual foods. The patient is advised not to move about too strenuously and to report any burning sensation in the perineum. Dry heat or medicated cold compresses generally relieve ordinary discomfort. After removal of any sutures about the eighth day, an oil enema is given to empty the rectum.

The patient may sit up in bed the day following labour and is advised to lie on her stomach and side and to move about and exercise her legs freely in bed. Sometimes she is massaged. She usually gets out of bed on the eighth or ninth day and is discharged from the hospital on the tenth or twelfth. Backache may be the result of difficult delivery or due to the straining of the sacro-iliac joints. A tight adhesive binder or a belt may be put on.

Care of the Breasts and Feeding: The mammary glands function as the result of concerted action of the lactation hormone of the anterior lobe of the pituitary gland influenced by the corpus luteum, in collaboration with small amounts of estrogenic substance. The breasts contain colostrum, a yellowish-white secretion, for the first two or three days. This acts as a laxative for the babe. After delivery the breasts and nipples are thoroughly washed with green soap and sterile water and a bland ointment on sterile gauze or wax paper is applied to the nipples. A binder is applied for comfort when the milk comes in. Before the babe is put to the breast the nipple is always cleansed with boric solution on sterile absorbent or gauze. This is repeated after feeding and the bland ointment re-applied to keep the nipples soft and free from infection. The nurse must always report any fissures in the nipples, any tenderness, redness or nodules, as immediate proper attention usually averts fissures or abscess.

The baby is usually put to breast for the first time eight hours after birth, and every eight hours for the first twenty-four hours, for three minutes each time; the second day every four hours for five minutes each time, and thereafter every four hours for ten minutes or longer, alternating from one breast to the other or to each from 6 a.m. to 10 p.m. and not during the night. Sometimes three-hourly feedings are given if the baby is small. After the milk is established, the nurse must never leave a baby at breast for more than twenty minutes at the very most, as the baby only chews the nipples causing cracks and infection.

Of course, the baby gets very little nourishment for the first two or three days but the nursing process stimulates the milk secretion and also the contraction of the uterus. Milk is generally established by the third to fifth day when the patient may have a slight temperature.

If weaning is necessary, put on a tight breast binder, apply ice bags, and restrict fluids. Magnesium sulphate may be given or the breast may have to be pumped. Stilbestrol tablets three times daily for four days are very effective.

Visitors should be excluded always when the baby is nursing, and for the first week only immediate members of the family should be permitted to see the patient and they but for a short time. Other people may be pacified by being shown the baby. Absolutely no visitors should be allowed in the nursery at any time. Persons with colds or other infections are a special source of danger to mother and child at this time. Children are never allowed to visit as they are more apt to carry infectious diseases.

The *cord* generally requires no special dressing after the first. Usually it comes off within the first week. After the bath, the stump should be dressed with dry boracic powder and sterile gauze dressing. Crusts can be removed best with 95 per cent alcohol. Infection in the umbilicus might lead to the death of the baby but if the nurse exercises proper care this is unlikely. Hemorrhage may occur from a too loosely-tied cord. It must be retied and treated carefully. In cleansing the navel, the nurse must separate the folds, examine carefully and swab thoroughly with pure alcohol. Always report any navel bulging as it might mean a tendency to rupture, needing compression.

COMPLICATIONS:

Puerperal sepsis popularly called blood-poisoning or "child bed fever" may be a very serious complication of child-bearing. Various local and general pathological conditions may occur following the invasion of the parturient canal during labour or the puerperium by pathogenic organisms. Puerperal infections must be looked upon as preventable conditions, in the production of which carelessness, error and introduction into the parturient patient of infectious material by the hands or instruments of the doctor or nurse may be responsible. In the conduct of labour the same precaution and aseptic methods should be used as are employed in the operating room. The labour and delivery rooms should be kept well ventilated. Masks of four layers of gauze should be worn over nose and mouth by all who attend in any way on the patient in labour, by the patient with a cold, and later by nurses doing perineum dressings. Masks should be changed when moist. Coughers and sneezers should be excluded from the labour and delivery rooms. Routine cultures from nose and throat should be taken. The doctor must use sterile gloves with plenty of disinfectant on his hands and gloves. He should avoid too frequent internal examinations. Strict cleanliness of the nurse's and doctor's hands and person, of the field of operation and the drapery is essential.

Causes: After delivery the raw surface in the uterus or any laceration in the vulva, vagina, or cervix may serve as a site for the entrance of bacteria. These may be naturally present (saprophytic) or may be introduced. Retention of lochia, blood clot or secundines may be predisposing factors. Stenosis or closure of the internal os due to a retroversion may cause retention of lochia with sapremia which may go on to septicemia. The patient may infect herself with her own hands. In the third stage the doctor should allow time for placental separation. He should examine the placenta for any retained portion or membranes, and repair any perineal or cervical laceration. Keep the vulva covered with a sterile pad during the first ten days postpartum.

Symptoms: Rise of temperature, usually on the third or fourth day, with chills and sweating; pulse — usually rapid, 120 up to 140, and thready. A temperature of 100 and a pulse of 100 should be specially reported as it is indicative of threatened sepsis; the uterus may be subinvoluted and tender; the lochia may be scant and foul, may become abundant in sapremia, or scant or absent in septicemia; if infection has spread to the peritoneum there will be tenderness over the affected organ; if peritonitis is general the abdomen will be tense and distended, with vomiting, rapid pulse and dry tongue.

Treatment: Technical skill and the judgment used in carrying out obstetric procedures are very important. Complete isolation of the septic case in a separate section of the hospital is most desirable with all precautionary measures. This isolation unit should be virtually a small complete hospital within the main hospital, with individual cubicles for each case.

Nursing care consists of: rest in bed in a well-ventilated room; fresh air — septic cases should all be put out in the fresh air on balcony or roof, with plenty of sunlight; the head of the bed is raised to increase drainage; ice bag to fundus to stimulate contraction; most nourishing food is given, with stimulants such as brandy, etc., forced fluids, nutrient enemata; cold sponging is refreshing with high fever and it promotes sleep; Russian oil and enemata are preferable to cathartics; baby is taken from the breast; nurse must take all precautions to avoid carrying the infection to herself or others.

Medical treatment includes: a careful examination which should be made to determine the cause or source of the infection, and treatment begun early; the sulfonamides or penicillin may be indicated; transfusions of immune blood are best, repeated if necessary; glucose intravenously or interstitially and serum given early; sedative — for sleep; ergot; iron tonic; any abscess should be opened and drained.

Prognosis depends upon the virulence of the organism, the severity of the infection and the resistance of the patient, which, of course, is low after having a baby.

Fissured nipple is due to improper antenatal care and lack of cleanliness; improper puerperal care — as failure to cleanse with boric solution before and immediately after feeding, or leaving baby to pull the nipple too long or neglect to warn patient not to touch the nipple.

Proper care generally prevents fissures. A fissured nipple is excruciatingly painful and apt to make a patient very nervous, so at the first sign of nipple trouble treat at once. When a fissure is present, nursing should be suspended; a bland ointment may be applied copiously to the nipple after cleansing with boric acid solution and drying. Sometimes the nipple is alcoholed and exposed to the air to harden it. An electric breast pump may be used every eight hours for twenty-four hours or longer giving the nipples a chance to heal.

Mastitis is generally due to infection, possibly through a fissured nipple. It is aggravated by chilling, catching cold, not dressing sufficiently warmly, congestion or insufficient emptying. The symptoms are: tenderness, caking — a lump with warm redness and pain in the breast; rise in temperature; chills; rapid pulse.

With proper early attention, breast abscess seldom develops. Report to doctor immediately; the breasts should be bound with a snug breast binder and ice applied over the tenderness; Epsom salts to mother or stilbestrol aid in the absorption of milk; fluids are restricted; breasts may be emptied by breast pump; if an abscess is evident by fluctuation, it must be incised and drained at once. It takes about six weeks for this to heal.

Either *melancholia* (depression) or *mania* (excitement) may develop the first month after delivery, mostly as a result of toxemia, puerperal infection, sudden grief or shock, especially in one with a delicate mental balance. This is often an inherited tendency. In the treatment of this condition, the baby is kept away from the mother and not allowed to nurse. There is danger of the mother injuring the baby. The breast pump may have to be used; sedatives are given to quiet and induce sleep; placement in a mental hospital is often advisable; constant nursing attention is vital. She must never be left alone.

The patient usually recovers. The more acute the onset and violent the symptoms, the better the outlook. As a rule she recovers in one to six months or never. There is always a tendency to recurrence.

THE LATE PERIOD:

Prior to discharge from hospital a gentle pelvic examination is done and any abnormalities are noted. These may be rechecked and treated as required after the sixth week examination. Following childbirth it requires about three months for the return of the uterus and parturient canal to the normal pre-pregnant state.

Of 9½ days' work lost by the average Canadian wage earner in a year, nine days is lost through sickness and non-industrial accidents and one-half day through occupational accidents.

The Nurse's Part in Prenatal Care

KATE MCILRAITH

Carolyn Van Blarcom has stated that "The nurse's part in a program for prenatal care is to assist the doctors in carrying out the prescribed details of supervision, instruction, and care of expectant mothers, and to work toward the ideal of having every expectant mother in the land under medical care from the beginning of pregnancy".

How can this be accomplished?

A great deal has been done not only by public health nurses but by the use of literature, that is, by books, the Women's page of newspapers, and the better magazines, where splendid articles on the different phases of maternal care are printed. But the important thing to be considered about maternity care is that there are still not enough people who know what it is in all its elements and not enough people are putting into practice what they do know. This is as true of nurses as it is of doctors and laymen. Yet, if there is one field in nursing that demands a combination of knowledge, skill and common sense, it is the maternity field.

In addition to acquiring a fund of knowledge and skill the nurse should have the ability to impart information to others. To do this she needs a genuine interest in what she is teaching, and in the people she is teaching, as well as a knowledge of teaching methods and of human psychology. In other words, what she does with her equipment of theories, facts, and skill is even more important than her possession of them.

In any prenatal program the nurse has a responsibility not only to the patient but to the doctor in charge, and to the community. She owes to the doctor her loyal support and confidence. She must realize that every detail of maternity care originates in, and is guided by, the medical profession. The entire scheme of prenatal supervision is but the interpretation and application of the doctor's orders for the health and well-being of the expectant mother.

In regard to her responsibility to the community, the magnitude of this obligation cannot be over-estimated since widespread prenatal work cannot be carried out without the whole-hearted support of nurses. The very future of our race depends upon her realization of this. For her active support and interest in this work to bear fruit, not only must she be familiar with what constitutes adequate prenatal care, but she must be imbued with a desire to convey this interest and enthusiasm, not only to her patients, but to the community at large. The nurse should have an understanding of the conditions which are destructive of life and health among mothers and babies and how adequate supervision will prevent these. She should know about the accompanying physiological changes and their meaning, the early, and even the very mildest symptoms of abnormality; how they are prevented and how to secure prompt attention when and if they appear.

Carolyn Van Blarcom states: "The thing to be burned and seared into the nurse's brain is that the ideal we are striving for, which she must help to achieve, is adequate care for each expectant mother. This means getting every expectant mother under care and then making that care so satisfactory and effective that it will save her and her baby. To reach that end we need to have complete and skilful maternity service more widely available in this country and the lay public so widely convinced of the pressing urgency of good care in all cases that such care will be demanded!"

"What we need, apparently, is not

that the high peaks of obstetrical work shall be higher, making it possible to save a few mothers from rare complications, but that the *average of the care given to all patients shall be raised.* Every detail of the care and supervision of even so-called normal cases should be regarded as of such importance that it will be performed with utmost pains. *Every expectant mother should be taken seriously. This should be repeated over and over and never lost sight of.* Every expectant mother should be taken seriously!"

The real test of the nurse's knowledge of maternal care is reflected in the activities and attitudes of the patient and those of the whole family. The starting point with each patient is based on what that patient knows about motherhood and her ability to absorb further knowledge. The average woman needs to know *why* rest, good diet, exercise and medical supervision are important to her and her baby. She needs to realize that her baby is already nine months old when he is born. She needs to be convinced that details of care which seem to be wholly unrelated to her own or her baby's welfare will actually increase their chances of life and health, and that by caring for her own health she is caring for her unborn baby.

The nurse must win the trust and confidence of her patient or patients before she can do any teaching. This can be accomplished only if the patient feels she can rely upon the nurse's ability and sincerity. The nurse's duty to the patient might be divided roughly into three parts: (a) watching or supervising; (b) teaching; (c) sustaining or giving moral support.

Let us look at the first one — watching; the nurse has an opportunity to observe the patient carefully between the doctor's consultations with the patient and report to him anything out of the ordinary that she notes. She can sift through the symptoms and give him a detailed report. Such symptoms are, for instance, headache, which may be significant of some complication or merely that the patient has been in the habit of sleeping until late in the morning with her windows all closed; constipation or fatigue which may be in itself alarming, or may result merely from wearing improper clothing and having inadequate rest. One is reminded at this point of the lady who walked four to six miles per day until the day she went to the hospital. She did not realize that walking on city streets is much more fatiguing than walking down country lanes. After her baby was born, she told us of this tired feeling but it did not occur to her to tell her doctor of her long brisk walks. She thought it too trifling for mention although he was trying to account for the undue fatigue.

Too much emphasis cannot be placed upon the value of complete pictures of the patient both mentally and physically; depression in one who is ordinarily cheerful; a newly-developed tendency toward carelessness. These as well as the fatigue may be first symptoms of a toxemia and should not only be reported but watched carefully.

The significance of an elevation of temperature, testing the urine for albumin, watching for varicosities, the care of the nipples and breasts, the need for rest, exercise and sleep, proper nutrition and its effect on the health of the mother and baby are a few of the points carefully explained by the nurse on her visits.

The teaching can be roughly divided into: (1) Teaching the mother the importance of prenatal care — that is, adequate medical supervision and proper health habits for herself, finding out the doctor's orders and interpreting and emphasizing the importance of following them. (2) Teaching her something of what is taking place in her body, what to expect and what symptoms to report. (3) Teaching her how to prepare for her coming baby, what clothing and equipment are essential for its proper care. It should not be necessary for a mother to give a *carte blanche* order to a saleslady in a baby department, whose primary object is to make sales, the more the better. (4) Teaching her the symptoms of the onset of labour, how to prepare for home delivery so that the doctor and nurse can give her skilled, efficient care with the minimum of confusion in her home or, if she is going to hospital, teaching her when to go to hospital and what to take with her.

At this time it is wise to teach her the value of having a trained person help her when she comes home from the hospital with her baby. It seems ludicrous that a new-born baby, after being given such excellent care in the hospital for the first two weeks, should suddenly be turned over to the care of a young mother who is totally unprepared. Too often, kindly but misinformed neighbours or "women" give the care. In one such case a "woman" was helping out the young mother by bathing the baby. This woman was not very well; she had just had quinsy but felt quite well enough to bathe a baby — "after all, it is not heavy" — to use her own expression.

If we ourselves are convinced of the value of breast feeding then let us remember that the groundwork is laid in the prenatal period. In the first two weeks in hospital every facility is used to get the flow of breast milk off to a good start. If this is to be maintained, let us assure the mother of adequate, understanding care at that most crucial time when she first comes home from hospital and has to fit the care of a new baby into her household regime while she is still far from strong.

The third aspect of the nurse's duty might be described as giving moral support or allaying fears. No two patients are alike, physically, emotionally, socially or financially. The attitudes, reactions and emotional difficulties of the patients are as important as their physical symptoms. Not every expectant mother looks forward with pleasure to having a baby. Some have a feeling of revulsion towards the change in their appearance, some look upon the thought of breast feeding with disgust. A common reaction to pregnancy is fear — fear of death, fear of labour, fear of marking the baby, to mention but a few. Very often these patients do not admit these feelings to their family or even to the doctor; sometimes, indeed, not even to the nurse. The nurse's attitude, her sympathy and understanding will do much to remove these difficulties.

More and more emphasis is being laid upon the tremendous part emotions play in the successful or unsuccessful termination of a pregnancy. A nurse inadequately informed or unsure of her knowledge is not much help here. The nurse must also be able to develop in the prospective father a sense of responsibility that may not have been there originally. Too often our own attitudes have helped the father continue in his belief that it is his wife alone who is expecting the baby. The nurse is in a strategic position to help both parents-to-be develop an attitude of genuine welcome to the new arrival.

To quote from Carolyn Van Blarcom again: "The nurse's part is to take hands with each patient, as she treads the long road of expectancy, pressing it warmly always, holding it firm over the rough places, and steadily giving the best she has to offer of tenderness, understanding and skill".

Preview

All of the problems associated with the care of children when they are well become greatly exaggerated when they are ill. The difficulties are further intensified when hospitalization is necessary. Linda Robertson has outlined for us some of the essential factors of the care of "Children in Hospital".

Group Teaching in the Prenatal Clinic

FRIEDA ALLUM *and* PAULINE MCKENDRY, B.Sc.

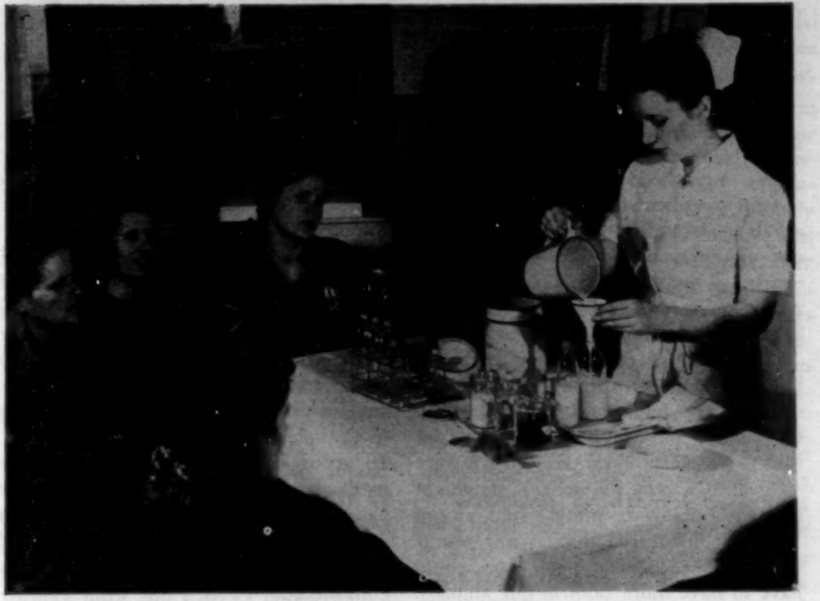
The great importance of prenatal care has been emphasized time and again, and most women today are aware of the advantages of this care, and seek it early in pregnancy. The Royal Victoria Montreal Maternity maintains a central clinic at the hospital, and four other clinics are situated in different parts of the city. At these centres women receive this service free of charge during their term of pregnancy, and are advised to return for a complete physical and pelvic examination six weeks after delivery.

The model patient is one who registers with the clinic early in her first trimester. On her first visit, she is interviewed by the social service worker, who investigates each new case to determine the financial status of the patient, and any woman who has the means to secure the services of a private practitioner is encouraged to do so. She is then given a complete physical examination by the doctor, her urine is tested, her blood pressure taken, as well as a blood Wassermann and hemoglobin. A pelvic examination follows and pelvic measurements are recorded. The normal patient returns every four weeks during the first trimester, every three weeks during the second, and every two weeks or even weekly in the third trimester. If there are any abnormalities additional examinations are performed, in which case the patient may be requested to enter the hospital. If the hemoglobin is very low, the patient is given blood transfusions and a high iron diet.

The Prenatal Clinic is a teaching centre. First, for medical students of McGill University, and resident internes, who, under the supervision of a staff physician, examine patients and discuss with him problems which may arise concerning each patient. Here also, post-graduate nurses and affiliated students receive part of their obstetrical training and are taught the importance of this type of service.

The clinic is primarily a teaching centre for patients. Individual teaching is difficult and rather impractical with a large attendance such as ours, so to overcome this a series of lectures and demonstrations have been arranged, and patients are invited to attend these classes which are given by a staff nurse or dietitian twice a week. A bright and attractive room has been fitted up as a class-room. Pictures selected from a portfolio of thirty-one teaching charts showing safe maternity care, which were obtained from the Maternity Centre, New York, are arranged where they may readily be seen and studied. A cheerful and informal atmosphere is secured in order to put patients at their ease. They are encouraged to discuss freely with the staff nurse their problems and worries.

During the first lecture, signs and symptoms of pregnancy are discussed, and the anatomy and physiology of the pelvis and its organs are illustrated by means of the Birth Atlas, prepared by the Maternity Centre Association of New York. The nurse instructs in personal habits, the type of clothing the patient should wear, and the food she should eat during this period of her life. The dietitian gives instruction in nutrition during pregnancy at the second class. She explains the reasons for restricting salt and protein and for taking additional milk and fluids. This class is given at two of our Settlement Clinics by a worker from the Diet Dispensary. The third lecture deals with the signs and symptoms of labour; the patient is also told about the care she will re-



Demonstration at the prenatal clinic

ceive in hospital, the value of post-partum exercises, and the need of an examination six weeks after delivery. The patients show great interest in the lecture dealing with baby care. The daily routine in the care of the infant is described and a demonstration bath given. The equipment used consists of a life-size washable doll, bath-tub, bath tray, layettes, baby basket, and diaper pail.

The fifth lecture of the series "artificial feeding", begins by discussing the value and importance of nursing the baby. So many of the women want to be able to get back to work quickly and are, therefore, somewhat indifferent to the proposal that they feed their infants. For those who are reluctant to adopt this ideal method, a demonstration is given of the equipment which is necessary for the safe handling of prepared feedings. This includes kitchen utensils, bottle rack, bottles, jars, nipples, and rubber caps.

For those patients who are having their babies at home there is a special class to help standardize the preparation. Their homes are visited during the prenatal period to check on supplies and to make suggestions about the arrangement of the room for delivery. Only multiparas who will have a normal delivery are accepted as home cases. These patients are delivered by a medical student under the supervision of an interne. This service is inexpensive for the patient and is maintained as a source of practical experience for the medical students and the nurses in training. The mothers and babies are given morning care by our nurses for tend days following delivery.

Our aim ever since the institution of this teaching program has been to make the women more fully alive to the possibilities of improving their living habits and to impress them with the fact that good care of themselves and of their children is not an expensive, vague and impossible thing, but something which all, who are interested in the welfare of the nation, are endeavouring to secure for them—that is, a safe and happy motherhood.

The Friedman Test

LILLIAN E. MARTIN

We have been using the Friedman test for pregnancy for the past four and a half years and have gradually worked out an apparently reliable system. As nearly as we can ascertain from our follow-up records we have better than 99 per cent average correct results.

The value of reliable animals cannot be too greatly stressed in achieving results with a high degree of accuracy. Originally, our source of supply for rabbits was very precarious and we were obliged to accept the seller's statement that the does were mature and virgin. We soon discovered that, if our results were to be depended upon, we would have to have more faith in our animals. Consequently we found a reliable person with whom we made a contract to supply us with healthy virgin does at least three months old and completely segregated eight weeks after birth, that is, the females are segregated from each other as well.

Eventually we decided that we preferred the medium-sized, short, straight-haired white animals (New Zealand), so our man raised only that type. We guaranteed to take at least twelve a month; usually we were well over the quota. In order to supply us with an approximate two hundred a year he had to produce double the amount to be sure of the required number of does. Our laboratory requirements for bucks are limited; six to eight per year are used in the preparation of our Wassermann hemolysin. While we have found the animals from this source to be very healthy we are anxious to maintain a high standard and if necessary check smears, cultures or growths for him.

To kill the animal we simply inject the ear vein with about 8 cc. of air and death is almost instantaneous. Not much of the animal is wasted; after skinning we remove the brain and process it to make the thromboplastin solution for the prothrombin tests.

Threatened with a rabbit shortage, I have anesthetized the animal and through a midline incision with a small instrument like a buttonhook (made by bending some old eye probes and dental picks) have drawn out the ovaries, examined and replaced them, then put in a couple of sutures to close the incision. In about six weeks the animal can be used again. These animals require more care and, while the method is fine in case of a shortage, we prefer one animal per test as being more sure and less time-consuming.

We keep a supply of well-washed 3 ounce wrapped bottles on hand to give to patients, with instructions. We ask them to have their evening meal as usual and whatever nourishment they are in the habit of having at bedtime, but absolutely nothing by mouth — food, fluid, drugs, etc., after midnight or until the first urine specimen is collected in our special container in the morning. The container is brought to the laboratory in the forenoon of the day collected. Specimens should be used fresh, although Mull and Underwood[1] add that if kept on ice the urine should be useable for one week.

The urine is checked for specific gravity and acidity, and the required amount filtered. Although most textbooks state a slightly acid reaction is more suitable, we get equally good results with either acid or alkaline. The specific gravity is a good check on concentration and if the specimen is too dilute, say 1.003, we ask for a repeat with further curtailment of fluid intake. However, some catheter specimens sent in from hospitals have a low specific gravity and we have obtained positive results on a few with specific gravity of 1.006.

When the urine is filtered, approximately 3 to 6 cc. are put into a small syringe with a 23 G1 needle. We do not use a rabbit box but firmly swathe the animal in a sheet or large towel. One operator controls the rabbit and holds the ear to be injected close to the head, shutting off the blood flow. The ear is flipped vigorously until a marginal vein is well congested. The hairs are plucked out — to show up the vein more clearly; it may be swabbed with xylol but we try to avoid this procedure as it seems to irritate and make the animal more jumpy.

Depending on the size of the animal, 3 to 6 cc. of the specimen is slowly injected, and this is repeated the following morning. In forty-eight hours the animal is autopsied and the presence of corpora lutea and corpora hemorrhagica noted. Sometimes we find one ovary with a positive reaction, while the other is quite negative. A repeat check on a new animal, however, has always shown a definite positive.

Occasionally the rabbit has violent convulsions and dies immediately on injection. This is usually caused by lack of co-operation on the part of the patient in the matter of taking drugs, or by the specimen having become old and contaminated.

It seems pretty well confirmed that the amount of hormone in the urine during pregnancy rises abruptly from conception to its height two weeks later and remains so to within two weeks of full term, from then on rapidly diminishing so that the urine at childbirth may give a negative or doubtful result. Therefore the specimen should be obtained not before two weeks following the date of the missed period if results of the test are to be reliable.

If the patient has an abortion the secretion of hormone may continue for a variable length of time — two days to two weeks. Attached placental tissue will give a positive result even in a partial abortion, so the doctor has a better idea of the condition with which he is dealing.

A weakly positive test may be of as much value as a decided negative or positive. It may indicate a tubal or unhealthy pregnancy which may terminate in miscarriage, according to Tenney and Parker.[2] Monthly pregnancy tests should be performed for one year after the removal of hydatidiform mole as a positive reaction longer than six weeks after evacuation usually denotes the presence of chorionic epithelioma[3] — to which DeLee adds "or a new pregnancy".

A Friedman test can be made on spinal fluid and seems of particular value in diagnosing hydatidiform mole and even seminoma occurring in a male with an ectopic testicle. Vesell and Goldman[4] claim that the spinal fluid Friedman test is negative in all pregnancies, normal or complicated, and in their series it has been positive only in cases of hydatidiform or seminoma.

McCullagh and Cuyler[5] in their series of fifteen cases of pituitary tumour, reported eight cases in which positive reactions to the Friedman tests were obtained.

The following case histories have been selected from among the patients of our clinic on whom Friedman tests have been performed, because they indicate the unusual cases in which the Friedman test may be of special diagnostic significance:

Case 1: Mr. W. M. S., age 44. There had been an increasing mass in the right testicle for two years. There was no pain and the patient thought it was related to a blow he had received in that region three years previously. His general health was excellent; Wassermann reaction negative, and Friedman urine test negative. Orchidectomy was performed and the pathological diagnosis was seminoma of the testicle. Patient is alive and well.

Case 2: Mrs. G. M., age 50. This patient was seen on March 22, 1941. Five months earlier curettage had been done and a diagnosis of hydatidiform mole made. Curettage was repeated in February, 1941, but no evidence of the condition was discerned. About four weeks before the patient was first seen she had noticed left temporal pain. The following day spots appeared before the left eye and on the next day the patient was completely blind in this eye. Swelling about the eye started two weeks later and was still persisting. On examination the left eye revealed marked proptosis. The pupil was occluded by fibrous exudate. On March 29, 1941, a Friedman urine test was positive and enucleation of the left eye was performed. Pathological diagnosis: Degenerating carcinoma. Patient was discharged from the hospital April 4, 1941. Follow-up could not be obtained.

Case 3: Mrs. A. B. L., age 23. Last menstrual period December 1, 1941. Usual period did not recur. January 1, 1942, spotting, intermittent vaginal bleeding and lower abdominal pain occurred. Pulse jumped from 70 to over 100 on January 31, 1942. Laparotomy was performed and revealed a right ectopic pregnancy. A Friedman test (urine) was done and was positive but the symptoms necessitated operation before results of the test could be returned. Patient is alive and well.

Case 4: Mrs. J. B. T., age 37. This patient was admitted to the hospital January 16, 1940, with lower abdominal crampy pains for one month, vaginal hemorrhage for six weeks, vomiting for one month. Patient stated that last normal menstrual period had occurred in October, 1939. A Friedman urine test was positive. On January 20 curettage was done. Pathological diagnosis on material sent to the laboratory; typical hydatidiform mole. Patient is living and well.

Acknowledgements: The author wishes to express her thanks to the doctors of the Calgary Associate Clinic for the use of the four case histories included above, and for their assistance and advice.

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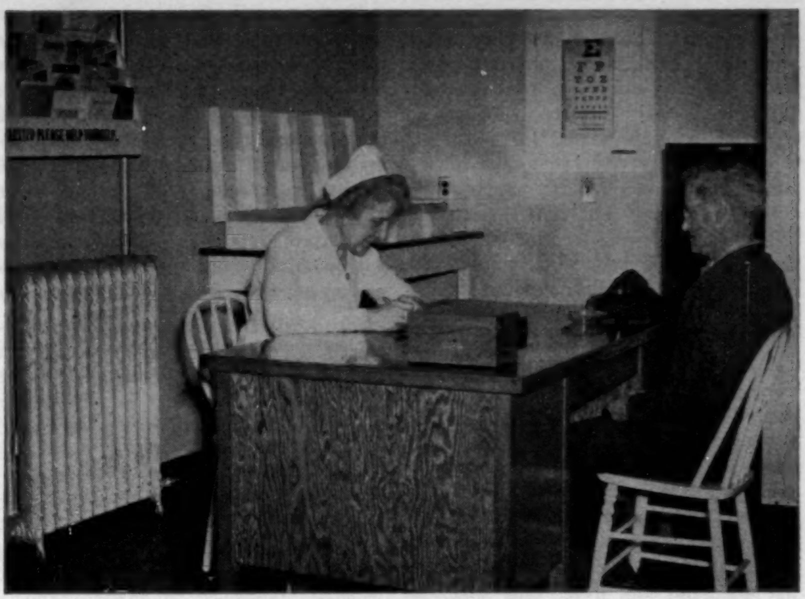
Health Program of Wartime Shipbuilding Limited

LOIS A. GRUNDY

The Allied world's need for ships became a major concern in the critical days of the war. More tonnage was being sunk than was being replaced by the output of existing yards. Construction of new yards was necessary. The time factor was paramount. The labour situation was rapidly becoming acute.

Wartime Merchants Shipping, later known as Wartime Shipbuilding, came into official existence in April, 1941. It is a Crown Company operating under the authority of the Minister of Munitions and Supply. Its job was to get ships built. Once the initial problem of getting this huge ship-building program underway, Management of Wartime Shipbuilding became concerned with the major problem of maintaining manpower supply. Production schedules were operating twenty-four hours a day and seven days a week. Labour was being



Nurse's office, showing eye chart and pamphlet rack

drawn from men rejected by and discharged from the military services, men in their late fifties who had retired from active manual work, youths under military age and women. The majority of the employees were new to shipyard work and in addition to having to be trained in their trades also had to be educated regarding the hazards of the industry. Steps had to be taken to reduce turnover and to keep everyone fit and on the job. Unions felt that such trades as mass arc-welding, acetylene-burning and spray-painting might have health hazards which would prove injurious to the health of their members.

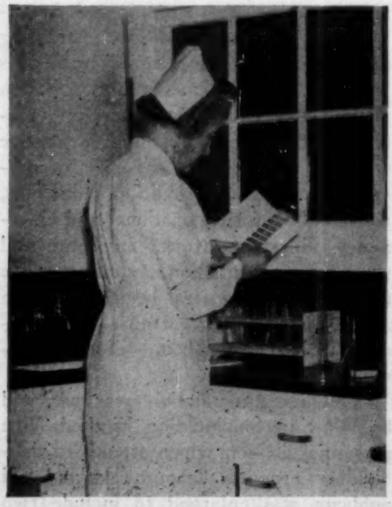
Wartime Shipbuilding requested the B. C. Medical Association to recommend an industrial health program that could be adapted to the Shipbuilding Industry. In 1942, the committee on Industrial Medicine of the B. C. Medical Association, after a careful study of B. C. ship-yards, found that the major yards were located in the metropolitan area of Greater Vancouver and were easily accessible to medical, hospital and ambulance services. A survey of the first aid facilities, for accidents and ordinary sickness, showed that first aid stations for both men and women were conveniently located throughout the yards. First aid treatment was administered by attendants who had had special training and held Industrial first aid certificates issued by the Workmen's Compensation Board. The Committee, therefore, recommended that a full-time preventive service be established to consist of pre-employment and periodic examinations, consultations for occupational and emergency illness at work, environmental supervision, sanitation, communicable disease control, general health education and, in addition, act in an advisory capacity to the first aid and safety departments.

This recommendation was accepted by Wartime Shipbuilding Limited. The personnel division which attends to shipbuilding progress, labour relations and publicity was enlarged to include two new divisions: medical and safety. A medical director, supervisor of nurses and a medical officer for each plant were appointed. The safety program was placed under a safety co-ordinator acting in an advisory capacity to the safety departments of the yards.

Each yard agreed to equip and maintain medical suites and to pay for the necessary nursing and clerical services. These divisions were to function under the direction of and be responsible to the medical director of Wartime Shipbuilding.

A half-time doctor is employed in yards with under twenty-five hundred employees; a full-time doctor with twenty-five hundred and over. Our nursing and clerical staff has been one nurse to approximately three thousand employees; one nurse with clerical assistance for three to four thousand and two nurses for four to five thousand; two nurses with clerical assistance for five thousand and over. One first aid attendant is employed for every five hundred employees.

The nursing staff assumes the nursing duties and the direction of the clerical staff necessary to carry out this preventive program. They establish and maintain office routine, take all personal histories and assist the doctor. Blood samples are taken for tests for syphilis. Hemoglobin readings, urinalyses and other routine tests, such as vision, hearing and blood pressure are done. Follow-up work arising from examinations and consultations is recorded and filed for future reference. Suitable referals are made to family physicians, clinics and agencies.



Nurse's laboratory and work centre.

From fifteen to twenty minutes is required for a physical examination. At times the number of employees to be examined was too great for the doctor and a screening method was necessary. The nurse was allowed to pass men whose medical history was clear within certain age limits and who were to be employed in certain specific jobs. Arrangements were made to recall these men at a later date for a complete physical examination.

Vitally important to this type of service is the building up and maintaining of adequate records, if statistics of any value are to be compiled. In addition to the individual history record which contains all pertinent information, a day book of all office visits, classifying the reason of the visit, the disposition of each case, the laboratory work and follow-up work is kept. A weekly report of all office visits properly classified, with disposition and synopsis, is sent to the medical director.

The physical examination is similar to insurance and life extension examinations. Pre-employment examinations are used to place the worker in jobs suited to their physical and emotional status, where they are least likely to endanger their health or cause injury to others. Periodic examinations are done at intervals to check health effects of their jobs and to find early signs of occupational illness. By these examinations and consultations, observation of individual health is maintained.

During the past two years physical examinations have been the principal activity in the medical division. Several reasons made this necessary: (1) Over twenty thousand were already employed in the B. C. ship-yards at the time of the establishment of the medical service. The payrolls were built up in six months to over thirty thousand. There was a monthly labour turn-over of 6 to 8 per cent. (2) There was need for periodic examinations of certain trades where health hazards were likely to exist. All requests for change of occupation for health reasons had to be recommended by the yard doctor. (3) All women workers were to have an annual examination. (4) Labour within certain age brackets was frozen. Among this group were a number with work limitations. National Selective Service was required to direct this group to industries of high priority rating. Our division has been helpful to National Selective Service by classifying medical releases as follows: T1 — Totally unfit to work in ship-yards; T2 — Terminated for a specified period for medical treatment; T3 — Terminated because no suitable job was available in that yard.

The Vancouver area is well supplied with excellent public health services; we have received the fullest co-operation from all these groups. The Vancouver Metropolitan Health Committee is available for advice on many technical questions. Their well-organized public health nursing service is available for home visits. This Committee is responsible for communicable disease control and notifies us of ship-yard workers who are contacts of certain communicable diseases. These workers are given instruction regarding the signs and symptoms of the disease, the incubation period, and are required to report to the yard medical officer at stated times during this period for examination.

The Provincial Laboratory has examined over seventeen thousand blood samples for syphilis; about 1.5 per cent were positive. Well over four hundred other tests were done which include sputum, swabs, stool and urine cultures for food handlers.

The diagnostic and treatment services of the Provincial Board of Health, Venereal Disease Control, are used. We report all positive bloods on a new industrial survey form, which includes the name of patient's family doctor and the date and time of a clinical appointment. When the patient reports either to his own doctor or to the clinic, we are advised of the diagnosis and whether the patient is in the infectious stage. If he fails to report we follow the case and make suitable arrangements.

The Provincial Division of Tuberculosis Control provides survey, diagnostic facilities, social services and hospitalization. To date nearly twenty-two thousand chest x-rays have been taken. A survey last Spring covering most of Vancouver ship-yard workers showed that 1 per cent of those x-rayed were diagnosed as tuberculous. Only one-third of the cases were in need of active treatment; slightly more than a fifth of this number after receiving treatment have returned to work in the industry.

Industrial engineering and sanitation services are provided by the Dominion Department of Health and Welfare.

Pamphlet racks in the offices are kept well supplied with literature. A wide range of subjects, covering many aspects of adult health, are available.

All these services are available to the worker without cost; largely as a result of these facilities, the annual per capita cost of the ship-yard health service is under three dollars.

Our records show, that of the sixty-four thousand office visits, 87 per cent returned to work following the examination or consultation with the plant doctor. An office visit requires a half to one hour of the workman's time and without such a service he would lose the greater part of a day to consult an outside doctor; thus a tremendous number of man-hours of labor are saved.

A study was made of the 13 per cent who were taken off work. These were divided into three groups and classified under thirty broad headings. The first ten reasons were listed for comparison and study as follows:

1. Those who were acutely ill — or in need of immediate medical attention: upper respiratory infections, 22.8 per cent; old injuries and deformities, 14.2 per cent; other alimentary conditions, 7.3 per cent; eyes and vision, 7.3 per cent; ears and hearing, 6.2 per cent; dermatoses, 6.2 per cent; chest conditions other than tuberculosis, 5.2 per cent; arthritis and rheumatism, 2.7 per cent; acute infectious diseases, 2.5 per cent; general debility, fatigue, etc., 2.3 per cent. The first ten causes accounted for 76.2 per cent of this group.

2. Those who for medical reasons were rejected or terminated from shipyard work: old injuries and deformities, 15.6 per cent; chest conditions other than tuberculosis, 11.0 per cent; neuroses, 8.3 per cent; arthritis and rheumatism, 7.2 per cent; heart disease, 7.2 per cent; peptic ulcer, 5.9 per cent; general debility, fatigue, etc., 5.2 per cent; eyes and vision, 5.1 per cent; ears and hearing, 3.7 per cent; upper respiratory infections, 3.6 per cent. The first ten causes accounted for 72.8 per cent.

3. Those who due to pre-existing or occupational conditions required a change of occupation: old injuries and deformities, 20.6 per cent; pneumatic arm, 10.0 per cent; fumes, 8.6 per cent; chest conditions other than tuberculosis, 8.6 per cent; general debility, fatigue, etc., 6.0 per cent; arthritis and rheumatism, 5.3 per cent; eyes and vision, 4.6 per cent; upper respiratory infections, 3.7 per cent; ears and hearing, 3.5 per cent; other alimentary conditions, 3.3 per cent. The first ten causes accounted for 72.2 per cent.

Here we found an interesting development, a condition termed "pneumatic arm", which may occur from the use of pneumatic tools. This is a compensable condition. If recognized early and the occupation changed to work without much strain, a rapid improvement may be expected. If allowed to progress, inflammation or even organic changes supervene. In one year, of the sixty-four claims for lost time from compensable illness, thirty-five were for "pneumatic arm".

From a study of the general records the following conclusions are drawn:

1. Conditions found at the physical examination were probably quite similar to those of the same age group in the general public.

2. Women, some of whom have had their third physical routine examination, showed a general history of good health with few occupational illnesses.

3. Occupational illness is not a major problem in our yards.

4. Analyses of paints show that very little lead paint is used in the ship-yards. The hazard of lead poisoning is not an important factor.

5. Welding and burning fumes, as far as can be determined, have not been responsible for any change in the type or degree of illness in the Vancouver shipyards. Repeated examinations and consultations show that welders and burners enjoy at least as good health as do other tradesmen. Other findings show that welding and burning fumes have no specific part in the cause or progress of tuberculosis. No case of acute pulmonary edema or fume fever has been reported. Chemical analyses do not show dangerous concentrations of fumes.

Prevention is a 'long-term' program. In some respects the degree of efficiency reached can never be determined. Past and present figures can be compared, if there are past figures. In a war industry they are rare. Sickness absence rates, previous to two years ago, are not available.

Figures for one aspect of prevention can always be obtained. Industries are responsible for the cost of medical treatment, lost time compensation and accidental deaths as a result of occupational injury and illness. Fatalities in the steel ship-building industry were eighteen accidental deaths in each of the past two years.

The trend of industrial accidents in the other major B. C. industries has been upward. In 1944, compensation rates for heavy industries varied from 11½ to 3 per cent of the payroll. Frequency and severity rates of ship-yard accidents were substantially down compared to 1943. The corresponding reduction in compensation rates resulted in a saving to B. C. yards of over half a million dollars. This was attributed largely to the work of the safety, medical and first aid departments.

This type of health service produces tangible and intangible benefits. Some of the tangible results are that workers are supplied with the knowledge of correctable defects, the early signs of degenerative disease and the necessity for treatment. Appointments are made with the family doctor and the clinic. By recheck examination their response to treatment is observed. Where a health hazard is found, suitable control measures are instituted.

Among the intangible results, which cannot be readily evaluated, is the opportunity to assist with the adult public health education of the community by individual health teaching and the interpretation of the functions of the existing agencies. General health supervision has maintained and improved the health and earning capacity of the workers. This has resulted in improved morale, healthier and happier workers, reduced accident rates, better labor relations, improved work, the saving of hundreds of thousands of dollars and the production of more ships.

Tuberculosis Survey of a Rural Municipality

In June, 1944, the first x-ray survey of a rural municipality in Manitoba was conducted by the Manitoba Sanatorium staff using a 35 mm. machine. The district covered was about twelve by thirty miles and the population, consisting of French, Belgian and Anglo-Saxons, numbered between three thousand and thirty-five hundred individuals.

The request for the survey was made to the superintendent of the Manitoba Sanatorium by the Council of the Municipality. The doctor in charge of the survey work met with the Council and outlined the organization which would be needed and suggested the type of publicity which would be most effective.

A letter explaining the purpose of the survey was drafted and also a poster announcing the date and time when each district should report to the survey centre. The Municipality was divided into districts with one councillor responsible for each. He saw that every family received a copy of the explanatory letter and that posters were put up in conspicuous places and he also arranged transportation for families unable to provide their own. The interest of the clergy was enlisted and an announcement of the survey made at services on two Sundays previous to the date set.

The more such a project can be a truly community effort the more successful it is likely to be, so the public health nurse left most of the organization and publicity to the committee. She was busy meanwhile visiting the convent schools and any family which any councillor felt needed further persuasion.

The Committee, headed by the secretary-treasurer for the Municipality, also arranged for volunteer helpers for each session the survey was operating and included three registrars, two helpers for the women's dressing rooms and one for the men. The survey ran six days from 2.00 to 5.00 p.m. and 7.00 to 9.00 p.m.

Survey quarters were the basement of one of the churches and adequate privacy for dressing rooms and x-ray was provided by the liberal use of clotheslines and sheets.

A total of 2,807 availed themselves of this opportunity. It is rather interesting to compare the first travelling clinic held in this district in 1928, with the present survey. In 1928, of 176 people having x-ray, 13 had tuberculosis, 7 being diagnosed for the first time. In 1944 out of 2,807, 12 had tuberculosis, 4 being diagnosed for the first time.

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Milk is a Valuable Food

Milk is not a perfect food but is the best individual one known. It contains materials which produce energy, foster growth, take care of the repair of worn out muscle tissue, and which, together with vitamin D, can look after the formation and upkeep of bones and teeth. It is a fundamental food for human beings of all ages. However, milk does not contain all the food requirements in correct proportion. It is about 84 to 85 per cent water. It contains an emulsified fat, commonly known as butter which is chiefly digested in the stomach. All other food fats take much longer to break down and are digested in the intestines. The protein of milk has all the factors which sustain life as it contains important minerals and vitamins. However, it is deficient in iron, iodine, vitamin B_1 or thiamin and vitamins C and D.

Milk is a "Jekyll and Hyde". Considered a fine all-round food, at the same time it is a culture medium for fermentative, putrefactive and virulent disease germs. Dr. John R. Fraser, of McGill University, has stated that "unsafe milk has been responsible in the past for more deaths and illness than all other foods grouped together". And even clean milk can be unsafe, despite all possible precautions at the source of supply. Therefore, milk must be put through some process that will kill disease germs before it is bottled in order to make it safe. That process is pasteurization.

—Health League of Canada.

Obituary

Nurses throughout Saskatchewan and elsewhere in Canada learned with deepest regret of the passing of the late Dr. W. C. Murray, President Emeritus of the University of Saskatchewan. Those who have been privileged to know Dr. Murray and to have had personal contacts with him realize that in his passing the nursing profession has lost a real friend.

The Nurses Registration Act passed in Saskatchewan in 1917, and many other progressive developments affecting the nursing profession, were due in a large measure to Dr. Murray's support and unfailing interest.

At the time of his death Dr. Murray was also chairman of the Board of Governors of the Saskatoon City Hopsital. A fitting tribute to his untiring efforts in this capacity was paid by graduate and student nurses from the Saskatoon City Hospital who attended the funeral and formed a guard of honour while bidding silent farewell to one whom they had always held in high regard.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

The Ideal Characteristics of a Nurse

L. EVELYN HORTON

In a nursing school the importance of keeping the ideal characteristics of a nurse paramount is of vital importance, not only for the director and instructors, but the entire nursing staff personnel including supervisors, head nurses, and general staff duty nurses.

Possibly in no other profession is example and precept so important as in the nursing profession. Every staff duty nurse whether she wants it or not is going to be a teacher. Next to experience the best of all teachers for nurses as well as other pupils is a good example. No nursing staff can hope to attain the best standards for the students in the school unless each and every one is willing to sacrifice.

The characteristics of a good nurse may be divided into three groups:

1. Certain traits are basic to good nursing and rest upon already accomplished habits and attitudes.
2. Other traits are also basic to good nursing and can be acquired in training.
3. Still other characteristics are special nursing skills, which can be learned only through constant practice and study in training.

The student nurse is made aware of these characteristics on application, and in introductory lectures after entrance. As many of these characteristics are acquired through training, it is essential that they should be kept constantly before her as a goal. This is the responsibility of all members of the nursing school faculty and especially the supervisors and head nurses because of their constant contact with student nurses during the immediate situation where these necessary characteristics or the absence of them will be displayed.

An outline of these characteristics with which we should all be familiar will be discussed under the three groups noted above:

1. The basic prerequisite traits upon which the acceptance of a student into a school of nursing is based. These are fundamental traits, which can be changed only with extreme difficulty, if at all.

(a) Is healthy—physically and mentally (full discussion, pages 44-46, Mental Hygiene for Nurses, Vincent). A complete physical examination before entrance is essential. Health is defined as that quality of life that enables us to live most and serve best. The nurse who herself is exhausted cannot give good service.

(b) Good intelligence — the value of intelligence tests for applicants is debatable. They are being carried out by some schools of nursing before acceptance of students. As junior matriculation has been set as a standard, and as a definite degree of intelligence is considered necessary for a student to achieve junior matriculation (I.Q. 107-120), many educationalists believe this to be sufficient for entrance. All schools of nursing would do well to raise their standards of entrance to senior matriculation. A record of the students' academic experience and the marks made gives a valuable clue as to what can be expected of her in the school of nursing. Generally speaking, from experience I have found a student can be expected to continue at about the same level. Where she possesses other qualities essential for nursing her success is more assured than if she lacks these qualities.

(c) Personality is of very great importance. What the nurse *is* as a person, is as important as the skills she will acquire in nursing procedures. We do not always show consistency in our personality traits — they change with emotional variations. The nurse like the gifted actress must possess a versatile and flexible personality. She must be a real person. As Emerson Fosdick has put it in his recent book, "On Being a Real Person," "Personality is not so much like a structure as like a river . . . it continuously flows, and to be a real person is to be engaged in a perpetual process of becoming". He also says, "A real person is integrated, and achieves a high degree of unity within himself. Some individuals are like a brush heap, a helter-skelter, miscellaneous pile of twigs and branches; others like a tree include the same kind of material but are organized into a vital growing entity. As growth continues, selves appear. There is the self one is at home, the self in business, in church, the golf links, etc. Often these multiple selves are in bitter conflict — Dr. Jekyll and Mr. Hyde. Personal wholeness and unity is necessary for happiness and health".

"Happiness", said Dr. William Sheldon, "is essentially a state of going somewhere wholeheartedly, one directionally, without regret or reservations". To be all at odds with oneself is to be unhappy. Many of the great people in the world have had a desperate time finding themselves. Florence Nightingale wrote in her diary, "In my thirty-first year I see nothing desirable but death".

The nurse's personality plays an important role in the sick room. In addition to nursing care the nurse has many other relationships to the patient. Her professional competence is usually taken for granted and it is often in these other relationships that she can find unique opportunities to promote the welfare of the patient and guide him forward toward recovery. The nurse must be able to adjust to the sickness situation, and the complexity of moods and attitudes that characterize most sick persons. Courageous optimism must be one of her permanent personality traits. She must have an even temperament, not moody or easily depressed. She must be able to maintain courage in others, renew hope and strength, be dynamically sympathetic. The nurse should cultivate individuality, which will make her more interesting to the patient. In adjusting herself to the sickness situation the nurse's general cultural and educational background is of assistance. Visitors come and go but the nurse is constantly with the patient. The nurse who has a varied general education, who keeps well informed on the news of the day, including politics, books, plays, sports, and who is able to draw discriminately upon her own experiences and observation is not likely to lack appropriate topics of interesting conversation for the convalescent patient.

There is some skepticism among educationalists as to the value of personality tests. Actual observation in different situations, when the student is not aware she is being studied, is the best means of judging personality. The preliminary period in the nurse's training is well suited to this purpose. The value of personal recommendations depends on the motivation of the person writing them.

2. Other traits are also basic to good nursing, and can be acquired in training. These characteristics may be briefly

summarized as follows: (a) patience; (b) orderly methods of working; (c) control of one's temper; (d) an increasingly sympathetic understanding; (e) tolerance; (f) a cosmopolitan viewpoint and set of appreciations; (g) self-confidence; (h) ability to get along satisfactorily with other people.

If a student nurse already possesses these qualities, she is spared much effort in learning and will probably be able to reach a superior position in the nursing profession. If she needs to acquire many of them she will have to concentrate harder and work more seriously. Success sometimes is greater when a nurse has to struggle to develop herself. Struggle with one's self, if ultimately successful, gives one the finest possible basis for understanding and helping other people. Constructive criticism and praise well-earned will help students to gain these traits.

3. Still other characteristics are special skills which can be learned only through constant practice and study in training as, for example, acquiring skill and efficiency in: (a) manipulation of sterile technique; (b) handling patients; (c) recognizing symptoms; (d) making accurate and helpful observations; (e) hospital and sickroom routine.

These will come through serious study, prolonged practice, constant alertness to the necessity for learning everything possible about the profession. Since repeated performance is needed to gain efficiency in any art, the necessity of students being given the opportunity to repeat procedures which they are prepared to do is important.

The following are some general considerations regarding the educational program for student nurses. All members of the nursing school faculty should be prepared to assist both in building and carrying out the plan of education. Supervisors and head nurses should have a general understanding of the entire educational program both clinical and classroom, and see the relationship of their part to the whole. They have better opportunities than any other members of the staff to help the students to see the importance of relating theory and practice and therefore should be familiar with the fundamental principles of teaching and learning. These are outlined in "The Hospital Head Nurse" by Wayland. Of these I want to mention particularly the fifth, namely, "the importance of immediate application of knowledge". As soon as the student has been taught the theory underlying a procedure, and techniques have been demonstrated, opportunities should be provided for her to carry out the procedure in the real situation. If the knowledge previously taught is to function, guidance must be given in making the right application, and in knitting together theory and practice. Without this final step much of what is taught in the classroom will be wasted.

To carry out these steps economically and competently a program must be planned in each clinical division to which students are assigned and definite provision made for carrying out the plan.

In carrying out procedures on the ward, though they may have been well taught in the demonstration room, the student will need some additional instruction the first time she performs this procedure on the ward. It should not be necessary to reteach the lesson but simply to help the student recall what she has already learned, and apply it to the immediate situation. In many instances, depending on the nature of the procedure and the condition of the patient, additional assistance may be necessary the next two or three times treatment is repeated. Young, inexperienced students should not be exposed to nerve-racking ordeals without someone at hand to give them a sense of confidence. Supervision should be, therefore, more concentrated during the period when students are making their first adjustments to a new type of experience.

It is important to remember that individuals differ in their mental and physical capacities and reactions, and consequently that progress is an individual matter. We must learn not to expect all students to attain the ability of the superior students in any group. Also, we must be aware of the importance of comparing a student with other students in the same group, and not with more experienced students. The head nurse or supervisor should keep before her as a basis a knowledge of what can be reasonably expected of the average junior, intermediate, and senior student. By the consideration of these points and a knowledge of what to expect of an average student at different phases of her training the ultimate aim of nursing education will be more fully realized.

The following is a very general outline of the levels of ability which might be expected:

1. *The junior student* — A typed list kept up-to-date of procedures covered with preliminary and junior students and posted on the wards proves very helpful to head nurses. By the completion of the junior year, students should have had demonstration and practice in all the general nursing procedures and with sufficient supervision should be able to carry these out in the wards. The junior student should not be assigned to the critically ill or extremely difficult patient, or unusual cases. They should not be given full responsibility for any such work as medications, dressings, diets.

2. *The intermediate student* — Early in the intermediate year students should receive operating room experience, which gives them a keener appreciation of asepsis. They can now be expected to take more responsibility for surgical technique and other duties on the wards. They should perform the general nursing care and treatments more efficiently and with less constant supervision. During this term the student receives her obstetrical training which is in many ways an entirely new experience. However, she enters this department with a good foundation in medical nursing, surgical nursing, and operating room technique. The related lectures in obstetrics and obstetrical nursing if possible should be given concurrently with this experience.

3. *The senior student* — Much of the senior student's time is spent in affiliations and in special departments such as pediatrics, isolation, public health, out-patients' department, sanatorium, psychiatric. During her time spent on the wards it is reasonable to expect this student to carry some of the executive work and more advanced duties. This again should be done under careful guidance from supervisors and should prove invaluable in the training of the nurse for her future work.

The practical work card which is checked as soon as the student successfully performs a treatment, and which accompanies her from one department to another, should be of assistance to supervisors and head nurses, acquainting them with what the student is prepared to do, and also with the experience required by the student.

"The entire object of true education is to make people not merely do the right things, but enjoy the right things". — Ruskin.

Preview

Very much is being written in current magazines and the press concerning the return of the thousands of young men and women who are in the various services to civilian life. For months, too, the Canadian Broadcasting Corporation has had qualified doctors, psychologists and others speaking regularly on the same topic. We are glad to be able to present as our feature for June Dr. Ewen Cameron's very able presentation of this subject.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Setting the Social Climate

Mildred I. Walker

In the earlier articles dealing with the problems of supervision an attempt was made to show why and how the change from the authoritarian form of supervision to the more democratic form has come into being in public health nursing organizations. Two cogent factors have emerged from this new emphasis; first, that it is necessary that all members of the staff should be capable of adult behaviour; and, second, that if they do not seem to have the ability to accept their part in democratic thinking and planning, this fault may be due to some previous experience under a less favourable form of supervision. In other words, the public health nurse who is mature emotionally should be competent, not only to plan for and carry out her health program in the community but also to contribute her share to the thinking and development within the organization itself. We have seen that leadership is necessary to achieve these ends — leadership which in its truest sense provides for and encourages active co-operation from the whole staff. Given adequate leadership and well coordinated staff, supervision assumes a truly democratic meaning, and a democratic atmosphere or social climate is created within the agency.

The social climate which is developed within a public health nursing organization is an important factor to be considered. It directly influences performance in both the immediate and long-term supervisory planning. A social climate may be defined as the atmosphere or tone which results from the mutual relations of people through living and working in an organized, interdependent body or society. Let us make a study of the forms of social climates which may be set up within a public health nursing group through the interaction of its members and others directly and indirectly associated with the health service. Each individual might apply the information to her own situation and decide which climate would give the most satisfactory results in the light of her evaluation.

Studies which have been made indicate that there are three main climates which may be created: authoritarian, democratic and laissez-faire. It has been stated that "the varieties of democracies, autocracies and laissez-faire atmospheres are, of course, very numerous. Besides there are always individual differences of character and background to consider"[1]. When the nurse attempts to evaluate the social climate in which she serves on the basis of these experimental studies, she must consider all the factors of individual differences and background and evaluate them objectively. This will not be done readily because she herself is a contributing factor to the group reaction.

The following outline indicates the

methods by which the three varieties of social climates were created experimentally.

Authoritarian	*Democratic*	*Laissez-faire*
1. All determination of policy by the leader.	1. All policies a matter of group discussion and decision, encouraged and assisted by the leader.	1. Complete freedom for group or individual decision, without any leader participation.
2. Techniques and activity steps dictated by the authority, one at a time, so that future steps were always uncertain to a large degree.	2. Activity perspective gained during first discussion period. General steps to group goal sketched, and where technical advice was needed the leader suggested two or three alternative procedures from which choice could be made.	2. Various materials supplied by the leader, who made it clear that he would supply information when asked. He took no other part in work discussions.
3. The leader usually dictated the particular work task and work companions of each member.	3. The members were free to work with whomever they chose, and the division of tasks was left up to the group.	3. Complete non-participation by leader.
4. The dominator was "personal" in his praise and criticism of the work of each member, but remained aloof from active group participation except when demonstrating. He was friendly or impersonal rather than openly hostile.	4. The leader was "objective" or "fact-minded" in his praise and criticism, and tried to be a regular group member in spirit without doing too much of the work.	4. Very infrequent comments on member activities unless questioned, and no attempt to participate or interfere with the course of events.

The resulting behaviour in these artificially-created social climates demonstrated many tendencies which are of interest to the public health nurse. In the authoritarian climate the results of aggressive domination were shown by the participants; to the leader the response was submission and persistent demands for attention; there was hostility, criticism, expressions of competition, and ego-involved language; individuals who had proven to be leaders in the democratic environment became scapegoats in the authoritarian, made excuses and left the group; there was little incentive for initiating new projects; there was little smiling and joking, and there was tension due to frustrations when all goals were set by the individual in charge. Apathy disappeared when the authoritarian leader left the room, indicating that the removal of pressure gave release to the emotions. Strikes and symptoms of rebellious action occurred, the degree of rebellion or submission being dependent upon the pressure of forces from within as compared with the forces exerted from without. The unwillingness of the group to accept pressure was amply demonstrated.

In the democratic situation the interaction was more spontaneous, fact-minded and friendly. To the leader the response was free and on a basis of equality. There was a moderate amount of aggression. When the students transferred from the authoritarian or high-tension atmosphere to the democratic there were outbursts of aggression, confusion and running around until they became adjusted to the situation of less pressure and more freedom for setting individual goals.

The laissez-faire atmosphere, due to lack of direction and indifference on the part of the leader, soon indicated loss of interest and productivity although preference was expressed for this disorder rather than the rigidity of group structure created by authoritarian direction.

In the summary of the experiment, four main factors were found to create aggressive behaviour: (1) tension; (2) restricted space for free movement; (3) style of living; (4) rigidity of group structure. Aggression is the invasion of rights, as defined by the dictionary, and it challenges the supervisor to ask herself, "Is my direction imitating the authoritarian pattern? Is all the work being directed by me? Am I permitting my staff to set goals and attain them? Have I enough confidence in my own direction and the abilities of my staff to permit them an equal share in planning and working out the program? Do I dictate every step of the way? Do I emphasize techniques or principles? Do I permit flexibility in following procedures? Am I objective or fact-minded in my praise or criticism or am I 'personal'? Do I consider personalities or the total situation and the objectives of the program? Am I always constructive? Do I, in making plans for future work, discuss it first with the group, or do I make the plans and 'tell' them what they are to do?" The supervisor must remember that while techniques and principles are both necessary, principles are more fundamental. Techniques are to be applied in relation to the principles involved. Also that the total situation and the objectives of the program must be considered above personalities. In the truly democratic organization the group would consider its needs and plan accordingly.

In an attempt to be democratic the leader may err and create the laissez-faire climate because she does not wish to "interfere" with the staff in planning. Democratic leadership is not interference. There is a place for advice and guidance when the nurse has not time to find out all the facts in the situation and reach her own conclusions. The supervisor is the expert and as such is a resource for the nurse. Advice must be accepted too when the individual is too subjective, is too close to the case emotionally to make a decision, or is not sufficiently informed on the subject. Advice has its place but it must be reasonable and applicable to the specific instance. It is realized that sometimes the individual nurse may even be permitted to fail, because, providing no injury is done to the project, this failure becomes a valuable teaching experience for her.

When dissatisfaction is found among the staff, the supervisor should take warning of future trouble. Frequent resignations, rebellion, apathy, lack of responsible behaviour all may indicate an authoritarian climate to the wise supervisor. The executive who attributes a procession of resignations over a period of time to ill-health, "personality" problems and all the other excuses put forward, is acting blindly, and is not fact-minded. It may be the personality of the supervisor or it may be one member of the staff. If it is the latter who creates the difficulty, and the supervisor is democratic, fact-minded, the group will soon correct the problem. If the difficulty lies with the supervisor the situation is more difficult unless the supervisor is truly democratic and can evaluate herself objectively.

The first cause of aggression noted is tension. This is affected by the personality of the leader or supervisor. In the field of guidance and in administration, the social climate develops from the top down. The executive officer or the person who directs the service has been referred to as the planner, the integrater and the "spark-plug" of the organization. This is a big order but those who guide others accept this as a part of their responsibilities. Schell[2] says there are three qualities essential for a good executive. These are: innate interest in and affection for people; strength and power of personality; scientific trend of mind. This strength and power of personality may create tension or it may set up a democratic social climate through direction and example. Tension or pressure will be avoided if the leader or supervisor possesses these three qualifications and a democratic social climate will result.

The other three factors which create aggression—lack of space, rigidity of group structure, culture or style of living—may be found among a staff and the supervisor may not be able to correct them. As soon as there is an awareness of the situation, a remedy should be sought. If the difficulties cannot be overcome the supervisor should accept them, by-pass them, or resign from her position. She should not complain ineffectively. Restricted space causing lack of free movement may occur when there is inadequate office space for the staff. The office and conference rooms of the public health agency should fulfil the principles of health. They should be spacious, well-ventilated, well-lighted, clean and attractively decorated, and free from hazards. In the hospital pressure may be created through lack of free space because of the large number of people who live in a nurses' residence. Frequently, too, the hospital has been surrounded by other buildings leaving very little free space. One hospital, turning a liability into an asset, has made an abandoned reservoir into a swimming pool, to the delight of all the staff. Without leaving the grounds in off duty hours, the young people can acquire that coveted coat of tan to compete with those who may have more free time to go to the beach. Other hospitals have roof gardens for recreation. These assist in the release of pressure due to restricted space, and limited time. (Did you ever know a nurse who had enough *time?*)

Rigidity of group structure is frequently a problem which creates real difficulty for the nurse who serves the community, especially when the service is new. For her first six months or year the community watches her very closely, especially if it is semi-urban or rural area. They are suspicious of anything new especially if it emanates from the city. This is true also of the young teacher and in many cases the public health nurse may assist her to understand the mores and customs of that particular community. These group structures may be unknown to the new comer despite the fact they may be rigidly adhered to by the community. Any change creates a problem and probably considerable pressure. In pre-war days when personnel was more plentiful, many communities engaged only "home-grown" personnel. Hospitals closed their staffs to outside graduates. This has been broken down and we hope will be avoided in the future post-war planning for nursing services in Canada.

A style of living or culture may be a contributing factor to aggressiveness, creating pressure on staff. It may be that some nurse belongs to a cultural group which encourages an aggressive pattern of behaviour. It may be that she does not come from a home where all share equal status in the family unit. In her home situation, there may be one member much more dominant than the others which tends toward an authoritarian climate.

Of particular assistance to me has been the careful observation of the behaviour of students when transferred from an authoritarian climate to the democratic. The release of pressure creates confusion and lack of self-discipline until the student becomes accustomed to the atmosphere of lessened pressure. Some of our students show interesting behaviour reactions when they come from a hospital atmosphere which has been authoritarian to the democratic climate of a university school. Here they are accepted as graduate nurses who are sufficiently responsible to meet the requirements outlined in the university calendar, such as attendance, field trips and assignments. It is interesting that the general reaction is different each year but with some guidance the students make their adjustments and emerge with the form of behaviour acceptable for the public health nurse.

Our aim in supervision in public health nursing is to create the democratic social climate. We have been reminded there is no short-cut to democracy. It is slow, halting and beset with many difficulties. The expert in the situation may be impatient to get things done. She *knows*, and wishes to go directly to the solution of the problem as she sees it. However in the democratic climate it is not possible to have a one-man show. So the supervisor who is the expert must do all that is possible to assist all members of her staff to participate, share and contribute according to the ability of each individual. Richards[3] says, "Real teaching cannot be achieved without time, patience and genuine interest in human beings on the part of the faculty group". So it is in supervision in public health nursing. Democracy emphasizes personal worth of the individual; for the group, preeminence of the common good; that authority be derived from the group. The ultimate authority of a public health nursing agency is vested in the people served. They are the reason for the existence of the service. Lindeman[4] says "To be responsible does not mean to submit to authority. On the contrary it implies the joint creation of authority". A genuine atmosphere of responsibility is produced when all participants achieve personal dignity. If an individual is unhappy in a job, she can find plenty to criticize. The nurse on the staff must belong and she must feel her work is important to the program. It really takes determined effort on the part of all to create the democratic social climate. The good executive is a good teacher as well as a good leader. The democratic supervisor in her desire to be an intelligent leader will face her problems and accept the responsibilities of her position.

If the supervisor feels the behaviour pattern is not satisfactory, and there seems to be an unusual amount of pressure or tension, she should think of the four points which may play a part: tension due to personality problem of one individual thinking first of herself; restriction of space for free movement; rigidity of group structure; style of living or culture. Most important of all, the leadership should be positive, uplifting and integrating to give the staff the pleasure of knowing achievement.

It will take concerted effort on the part of all of us in public health nursing — administrators, supervisors, and staff—to make effective the democratic way of life. With a change in the meaning of supervision from inspection, superintendence or oversight, to that of guidance, it is necessary to change our way of thinking from the traditional or authoritarian to the democratic. This requires our constant consideration because we have been educated in the general field of education and in the special field of nursing by traditional or authoritarian methods. Public health nurses are truly interested and respond readily to group discussion regarding the creation and maintenance of the democratic social climate. Experience in the field of public health nursing indicates that the nurse who is attracted to this field has an outgoing personality. To function successfully requires a high degree of interaction which can only be maintained by respect for the individual and for group effort on the part of the whole staff where the contribution of each is equally important to the smooth functioning and maintenance of a well-integrated program of community service.

Supervisors and administrators are interested because they need to encourage those who show leadership qualities so that there will be a steady supply of qualified nurses capable of assuming greater responsibilities. Leadership emerges in the democratic process. The supervisor recognizes in the young nurse these qualities and then *guides* her by the democratic process of thinking and action. If there is a scarcity of qualified leaders in a field there has not been education for leadership. The nurse giving leadership tomorrow must be one who has the capacity for leadership, has qualified scientifically for it, and will assume gracefully the responsibilities which are a part of the position. She must think and act democratically and require this of her staff. This will be true leadership by which the democratic social climate may be maintained.

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Nursing Sisters' Association of Canada

At the recent annual meeting of the *Edmonton Unit* there was a record attendance. The president, Mrs. E. Porritt, was in the chair. Reports showed that the thirty-three members had raised about $500 which was contributed to Russian, Greek, Chinese and merchant marine funds, as well as to the British Nurses Relief Fund. After the meeting the hostess, Mrs. Harold Orr (N/S Margaret West), entertained at a turkey supper, a splendid climax to another year of successful endeavour. The majority of the members are engaged in various war activities and in April the Unit celebrated its 25th birthday.

The *Montreal Unit* held their annual Armistice dinner with fifty-six members present. The guest speaker was Mr. K. C. Woolley, secretary of the Canadian Legion. The Unit sent a letter to the Rt. Hon. Mackenzie King wishing to go on record as supporting in full the principle of total war and to protest the action of the government in ignoring the plebiscite taken by them regarding conscription. The Unit continues to assist the British Mine Sweepers Auxiliary in addition to other individual voluntary work.

In conjunction with the Red Cross, members of the *Toronto Unit* during the war have had three afternoon groups and one evening group working in their rooms at 2 Bloor St. E. Last year, under the leadership of Mrs. Jack Bell, these groups made over fifty-three thousand surgical dressings. Every Monday several members pack prisoner-of-war boxes. A bridge was held in April, the proceeds to go to war work.

Personal Notes: N/S Ethel Greenwood, for four years at Camp Borden, recently retired.

"STAMP OUT VD" CAMPAIGN

The Health League of Canada and the Canadian Pharmaceutical Association have joined forces to stage a special "Stamp Out VD" campaign from May 21-26. In this special campaign Canada's 3,865 operating druggists are being asked to co-operate through window, counter and showcase displays.

Special efforts will be made to interest youth in the fight against VD. About 75 per cent of all VD is acquired by persons under thirty years of age.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Day in an Indian Hospital

Olive Thomas

There are many nurses who have not the slightest conception of life in an Indian hospital, and yet there are such hospitals in every province of the Dominion. An Indian hospital treats the same variety of patients as any other. This one of which I write also has a department for tuberculosis.

In the early morning the usual routine is carried out by the night nurse, wakening and preparing all for breakfast. There is an added joy in the little girls' tuberculosis ward, watching these little bronzed people, with big black eyes, shining white teeth, smiling faces, displaying great eagerness to be awake and ready for the activity which comes with the daylight. While clasping an orange tightly in one hand, they dive into a bowl of porridge—for this must be eaten before they are permitted to enjoy toast, jam and milk. Next comes the bath, with clean linen and pyjamas. How they love pretty, clean pyjamas! Each is given her own with name attached. Thinking of conditions in some of their homes, one wonders at the criticism and look of disgust on a wee face if her sheet or spread, when opened up, displays a cocoa or medicinal stain, for which probably she was the guilty party on a previous occasion.

In addition to the routine duties in the hospital administration there is the activity in the out-patient department, which demands the full attention of one nurse. Frequently there is a steady stream of natives in and out of the doctor's office. Several dozen teeth may be extracted during the day. Prenatal examinations are routine and gradually are being accepted by the younger generation. Physical examinations are given; x-rays taken; fractures set; casts applied; many consultations are held and advice given to one and all coming into the office.

Suddenly a loud and persistent ringing of the bell calls the attention of every one. Looking out of the window one sees a sleigh drawn up to the door containing, what appears to be, nothing but a huge pile of quilts and blankets. On further investigation and unfolding of many layers, a child is revealed, pale, limp and emaciated. One glimpse of the trained eye and, immediately malnutrition registers on the mind. The mother reports that the child is *getting thin*, and since the previous day has been unable to retain feedings; the cry is weak and pitiful. The baby is admitted to the hospital amid the weeping and wailing of the parents, as the child has become too frail to give much encouragement for recovery. For the interest of the readers, I would add that the baby was discharged four months later, having developed into a sturdy little chap with no evidence of malnutrition remaining.

Another ring at the bell and, minus all ceremony, in rushes a young Indian with his wife following slowly behind. "My wife, she sick, Doctor home?" It takes but a few moments for the nurse to realize there is no time to lose. The young woman is admitted, put to bed, bathed and wheeled into the case-room. Not long after, a hearty protesting yell announces the arrival of a chubby infant; particularly fascinating is the heavy mop of black curly hair. In a short time the mother is comfortably settled and enjoying tea and toast. The young daughter is oiled, bathed, dressed and settles herself to enjoy her meal. Generally speaking, Indian babies are ready for a full course meal from six to twelve hours after birth.

The staff decides it is time for a moment of relaxation and retires to the living room for tea; unfortunately this recess is of short duration. A nurse is again summoned to the door as an excited twelve-year-old boy, holding one hand in the other, says, "I cut off my finger". He is taken into the examining room and, right enough, one finger is practically severed and others badly mangled. Once more the doctor and nurses get busy. The operating room is made ready, doctor scrubs, and the nurse administers the anesthetic. The finger is removed, wounds cleansed and necessary repair done on the hand and remaining fingers. The child is carried into the ward and into the only empty bed in this busy little hospital.

Thus ends the emergency work for the day. With the busy out-patients department, operating room and case room all brought into activity, not a dull moment is known.

Any nurse who thinks that life in an Indian hospital is an uninteresting and monotonous existence might take a few moments off some day, study conditions and accept a few facts from others who have learned from personal experience.

Concerning Shock

War, with all its horror, always adds to medical science and nurses will find the second edition of the Medical Research Council's War Memorandum No. 1 on *The Treatment of Wound Shock* a very helpful contribution to their knowledge as are also the many numbers of the Bulletin of War Medicine. These bulletins are published by His Majesty's Stationery Office, York House, Kingsway, W.C.2, or 13a Castle Street, Edinburgh, 2, price 6d and 1/3 per copy, respectively. The new edition of the Medical Research Council's Memorandum on the Treatment of Wound Shock differs extensively from the first edition, not because of the discovery of "any 'dangerous' statements" in the first edition but because fresh evidence, new points needing emphasis, and modifications of treatment have necessitated a complete rewriting. The new edition puts the present position of our knowledge of this difficult subject very clearly and is most valuable.

In this edition the word "shock" is put in quotes throughout, because of the great complexity of the "shock" problem — the many factors which help to cause it, and the various different manifestations associated with it. Among the causes, the memorandum stresses the importance of acute reduction of the blood volume or *oligemia*, resulting from hemorrhage or plasma loss, either externally, as in extensive burns, or internally into damaged tissues, as in crush injuries.

It also draws attention to the vasovagal collapse which not infrequently complicates the picture in hemorrhage and acutely painful injuries, even in trivial injuries in susceptible persons. Here a sudden fall in blood pressure occurs with a slowing of the pulse because of vasodilation, affecting especially the arteries in the muscles. It usually occurs early after injury, with a feeling of faintness or actual loss of consciousness, but it can occur late, and may follow manipulation, operation, or further hemorrhage when the first bleeding has been arrested.

Again the memorandum stresses the importance of early recognition when the appearance of the patient and the blood pressure may be deceptive. With regard to hemorrhage, it reminds us that a loss of up to two pints may be tolerated with little or no obvious effect or fall in blood pressure, because of the compensatory effect of vasoconstriction in the skin and internal organs. Indeed, it draws attention to the fact that in the early stages after injury there may even be a 'post-traumatic hypertension', (150-170 mm. Hg.), the cause of which is uncertain. Under these circumstances, it gives the good advice that every case of serious injury, with hemorrhage or without, should be treated for "shock" without waiting for clinical signs to appear.

In the section on treatment, there are many interesting points. First comes the statement that the longer the delay before treatment the greater the danger, so that resuscitation measures should, if possible, be followed by immediate operation or should be carried out in the theatre itself. The value of a special resuscitation ward where the patient can obtain the rest and quiet 'so impossible in a busy general surgical ward', and where measures to restore the circulation — a blood transfusion can be quietly carried out — is stressed. An interesting point here is the statement that the use of nine-inch blocks at the foot of the bed will often raise the blood pressure by 5 to 15 mm. of mercury.

As anyone who has followed air-raid casualty work closely would expect, the danger of tourniquets receives further emphasis. The memorandum suggests that, where they have been applied before admission, unless the limb has been damaged beyond hope, the tourniquet should be removed and, if hemorrhage recurs, local pressure should be applied on the bleeding point by means of strong bandages and several layers of wool bound tightly over the dressing.

The paragraph on warmth stresses the general change in outlook here. The suggestions are removal of wet and dirty clothes, warm pyjamas, a bed warmed with hot water bottles, and hot drinks. The more elaborate apparatus — the electric blanket, radiant heat bath or "shock" cage — are not mentioned except to condemn them in the statement, "More elaborate heating arrangements are unnecessary, and it is always undesirable to overheat the patient". The danger lies in vasodilation of the blood vessels in the skin, which can hold from a third to one half of the whole of the normal blood supply when the skin is fully flushed with blood. This, of course may increase dangerously the oligemia from which the patient is already suffering because of the sweating that it causes.

The *Bulletin of War Medicine* for November also touches on this point of warmth in "shock" in an abstract of an article by D. S. Dick from the *Lancet* of August 5. He had wide experience of resuscitation of battle casualties. The abstract states, "Wards were heated by paraffin 'Valor' stoves to about 80 degrees F., and hot water bottles were applied; the author concludes that the physical and mental comfort of gradual warmth probably outweighs the theoretical advantages of applying heat to shocked patients". As the nurse is the one who is generally responsible for the application of warmth it is important for her to understand the position fully, and the sentence in the memorandum 'enough cover and warmth for comfort are now thought to be the optimum' might well become her motto provided she remembers that 'cover' includes both what is under and what is over the patient.

Needless to say transfusion is discussed together with the risk of pulmonary edema, and interesting in this section is the fact that in a series of war casualties an average of three pints per case was required, and some severe cases needed an amount approaching the whole blood volume, that is, about ten pints. In fact, did not Glasgow record a case in which the total ultimately reached twenty pints? With regard to rate, 100 cc. per minute can be given in severe cases and if the veins are in spasm a hot water bottle laid over the arm will often relax them. If air pressure is used to force blood in from the bottle, nurses should keep in mind the warning that the bottle must be *disconnected before it empties* or a fatal air embolism will follow.

The administration of oxygen in high concentration which was advocated in the first edition has not, in practice or in experiment, proved satisfactory and the memorandum suggests that its use be confined to cases of chest injury or pulmonary edema, carbon monoxide poisoning and chemical warfare.

One other point of particular interest concerns crush injuries. Civil defence personnel have had instructions to give sodium bicarbonate by mouth and fluids, such as tea, coffee or water, if possible, before releasing from compression patients who have been buried for more than an hour. Such cases are labelled and should have two ounces of sodium bicarbonate hourly by mouth, till the urine turns red litmus blue, up to twenty-four hours. This is thought to prevent precipitation of myohemoglobin as acid crystals in the kidney tubules, and therefore to lessen the risk of death from renal failure, though the cause and prevention of this condition are still matters for further research.

—*Nursing Times*

What Do YOU Think?

What are your aspirations for nursing in Canada in the next few years? We have heard rumblings of discontent — but not enough constructive suggestions are being made. The *Journal* is exceedingly interested to know what the nurses of Canada think about the future of our profession. In order to find out, the Editorial Board has authorized the awarding of prizes for the best articles portraying the influences which will shape this future. What individual nurses think and do, what the profession does collectively, how the public, whom we serve, will shape plans, are all aspects which may be developed.

The competition is open to any Canadian nurse, graduate or student. The articles should be not less than five hundred nor more than a thousand words in length, written or preferably typed (triple-space) on one side of the paper only. Representative nurses from various parts of Canada will be named as judges. All entries shall be submitted to the offices of *The Canadian Nurse Journal,* 522 *Medical Arts Bldg. Montreal,* 25, and marked "Competition". The closing date for the entries will be *September* 30, 1945. The winning articles will be published in the *Journal.*

Prizes shall be awarded as follows: for the best article, $25; second and third choice, $15 and $10 respectively. Other articles of merit will be given honourable mention. It is understood that all articles must be original, have not been submitted elsewhere for publication, and become the property of *The Canadian Nurse.*

—M. E. K.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

At a recent conference called by National Selective Service with representatives of the Canadian Nurses Association, a careful analysis was made of the supply and demand of nurses for Canadian hospitals and public health services.

During the year the nursing personnel needs of the Armed Forces made fairly heavy demands upon Canadian nurses. It is not expected that the requirement for military nurses will be quite so great during the coming year, but the erection of new hospitals and additions to other hospitals will strain our reserve nursing personnel to the utmost.

At this time last year, when plans were made for recruitment of further nurses, it was believed that there remained a supply of married nurses who could give full or part-time service to their community hospitals, or could relieve the strain upon the private duty group. In answer to appeals, many married women re-entered the profession. This reserve is fairly well exhausted. It was, therefore, decided to again draw to the attention of hospitals the necessity for making full use of their professional personnel for highly skilled nursing service. The following suggestions were endorsed by the Liaison Committee:

That nurses' aides of suitable qualifications and preparation be used as much as possible to relieve the professional staff of all non-nursing duties.

That, where possible, every consideration be given to establishing group nursing for patients requiring the service of private duty nurses.

When a hospital is in a critical situation, insofar as nursing personnel is concerned, that the co-operation of the medical staff be sought in bringing about a reduction of the demand upon private duty nurses.

For those hospitals not already doing so, it is suggested that consideration be given to extending vacations for all graduate staff over a longer period of time, exclusive of Christmas vacation, and that, where possible, consideration be also given to the policy adopted by many business firms, namely, the granting of one week's summer vacation as a bonus for taking regular vacations during other periods of the year.

Many nurses who have not had experience in mental nursing or in tuberculosis sanatoria are hesitant about accepting positions in these institutions; the fear of contracting tuberculosis has also been a deterrent in the latter instance. It is realized that, although this may only be one factor, it is of sufficient importance to give concern and, for those hospitals not already doing so, it was suggested that an introductory program for newly-appointed staff be established, and that a planned program of staff conferences conducted by medical and experienced nursing staff be arranged. It is realized that this requires time and planning and, where possible, the co-operation of the provincial nurses association should be sought, and the services of the travelling instructor, to assist with organizing and conducting such programs, should be obtained.

As a means of maintaining interest

and encouraging nurses to remain for a longer period of experience, consideration should be given to the policy of issuing a statement of experience received at the end of six months' continuous service.

Nurses frequently object to accepting positions in special hospitals because of the isolation. It is therefore suggested that in these instances consideration be given to accumulative leave, which will allow for a brief period away from the institution.

An improvement in the organization of recreational facilities is also suggested as a means of providing personnel with much needed diversion.

British Nurses Relief Fund

We gratefully acknowledge the following donations received from the Saskatchewan Registered Nurses Association: Maple Creek Graduate Nurses Association, $25; A. A., Yorkton Queen Victoria Hospital, $19.85; Yorkton Nurses Voluntary War Services Association, $30. Total, $74.85.

Ontario Public Health Nursing Service

Frances Cooper (University of Toronto School of Nursing diploma course) has accepted an appointment with the Peel County School Health Unit.

Jane Fedchyna (Hôtel-Dieu Hospital, Windsor, and University of Western Ontario public health course) has accepted a position with the Windsor Board of Health.

Eileen Morris (St. Michael's Hospital, Toronto, and University of Toronto public health course) has accepted a position with the Oshawa Board of Health.

Alice Klugman (Toronto Western Hospital and University of Western Ontario public health course) has accepted an appointment with the Chatham Board of Health.

Elizabeth Petrie (University of Toronto School of Nursing diploma course) has resigned her position with the Chatham Board of Health to accept an appointment with UNRRA.

Mrs. Blanche Gordon (Toronto Western Hospital and University of Toronto public health course) has resigned her position with the Board of Health of Pickering Township.

Eleanor Wheler, B.A. (Toronto General Hospital and University of Toronto public health course) has resigned her position with the East York Board of Health to accept an appointment with the Department of Health of Prince Edward Island.

Mrs. Mary Donaldson (Proskerniack) (St. Joseph's Hospital, Port Arthur, and University of Toronto public health course) has accepted an appointment as epidemiologist with the Division of Venereal Disease, Ontario Department of Health.

Institute in Chicago

The Department of Nursing Education of the University of Chicago is offering an Institute for Supervisors in Public Health Nursing from June 4 to 9, inclusive. This institute is planned for the nurse who must meet supervisory responsibilities for which she has not had adequate preparation. There will be no registration fee; instructional costs will be met from Federal funds. Maintenance at the rate of $4.00 a day will be provided for those who do not live in the immediate vicinity. For further information write to Nursing Education, University of Chicago, 5733 University Ave., Chicago 37.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Post-Graduate and Added-Experience Courses

This is the first of a series of three brief articles dealing with post-graduate work available to nurses in Canada. The term "post-graduate course" is used to designate a course of a definite length in which carefully organized and systematic teaching is given. In contra-distinction to this, the term "added-experience course" has come to be used to describe the arrangement by which a graduate nurse is allowed to learn the work of a given clinical field or service by working in that field, usually with very slight accompanying teaching, and frequently with none. Thus nurses from small schools often go into the operating rooms of a large hospital to increase their knowledge of this field of work. The first type is usually found in a university school of nursing. While certain hospital schools do offer well organized courses combining theory and practice, these are decidedly exceptional. Many hospital schools when applied to for post-graduate courses refuse to call them this, because they do not give teaching, and prefer to say that they offer only "added experience." Particularly under present conditions, it is very doubtful whether hospital schools can do more than give added experience. Some who formerly offered post-graduate courses have discontinued them.

THE ADDED-EXPERIENCE COURSE:

The purpose of these courses is essentially to supplement the basic clinical training. Depending on that training and the position in view, such courses may occupy anything from a few weeks to long periods spent in one field. Actually the work does not differ from that of the general duty nurse on salary who had been taken on the staff without special preparation or experience in the particular field. It does not constitute a full preparation for this field of work even though the nurse is definitely of the opinion that she wishes to do only general duty by which she means that she does not wish to administer or teach in the department. It is inadequate because a satisfactory general duty nurse is inevitably called on for some administration at times, and because at all times she teaches in the sense that she should provide a demonstration of fine nursing care for new and junior nurses.

POST-GRADUATE COURSES IN UNIVERSITIES:

The university nursing schools of Canada offer mainly four types of post-graduate preparation: public health, hospital administration, teaching in schools of nursing, and clinical supervision. Any of these may be taken on either an elementary or an advanced level. In all cases they include both didactic instruction and practice in the appropriate field. In general they occupy one year, and lead to a certificate from the university. Two year arrangements are offered, but so far there have been no candidates for these (except from other countries).

COURSES IN PUBLIC HEALTH NURSING:

As few nurses have had public health training during their undergraduate courses, these courses are basic or preliminary training in public health nursing. Preparation is required before work is undertaken in this field. Such a course is now a required qualification for employment in nearly all positions in public health nursing.

In some universities, advanced courses are open to nurses who have had basic preparation for public health nursing, and who also have had experience in the field. The purpose of these is to give opportunity for further study to prepare for work in special fields, or for supervision and administration in public health nursing. Refresher courses are also offered at intervals for those in practice.

COURSES IN HOSPITAL ADMINISTRATION:

In Canada there are a large number of hospitals with nurse administrators. Nurses have a valuable hospital background, but the board of a hospital looks also for a person who can give business leadership, and can secure and maintain good community relationships and support. Recently there has been a growing trend toward formal preparation for work in this field. Such courses are open to nurses who have already had some experience in junior executive positions in hospitals. In addition to the major subject of Hospital Organization and Administration, courses are given in such subjects as economics, bookkeeping and accounting, legal aspects of hospital administration, psychology and public health.

COURSES FOR TEACHERS IN SCHOOLS OF NURSING:

These offer preparation for both classroom and clinical teaching. As nursing instructors are probably the people who have the greatest influence in the development of nursing, it is essential that nurses entering these courses should have high qualification personally, academically, and professionally. It is preferable that they should have had experience as general duty nurses, head nurses, or in the public health field. Preparation for these positions usually includes such subjects as psychology, sociology, education, teaching, and science.

Special courses are also offered for advanced or specialized work in nursing schools or hospitals, such as that of the director of a nursing school or the director of the nursing service of a hospital. For those already in the field, refresher and extension courses are offered from time to time.

COURSES FOR HEAD NURSES AND CLINICAL SUPERVISORS:

These represent the newest type of preparation offered by university schools of nursing. They are, in general, offered for young graduate nurses wishing to work in the hospital field; though even here it is desirable, but not essential, that the applicant shall have had at least brief experience in general duty or as an assistant head nurse.

As many nurses are not familiar with these new courses, the second article of this series will deal entirely with clinical supervision courses.

The third article will list post-graduate and added-experience courses available in Canada.

M.L.IC. Nursing Service

Alice Albert (St. Vincent de Paul Hospital and University of Montreal public health course) has returned to her duties as supervisor on the Frontenac nursing staff, Montreal. Miss Albert was loaned for a period of one year to the Registered Nurses Association of the Province of Quebec.

Jeanne d'Arc Hamel (St. Sacrement Hospital, Quebec) was recently transferred from Montreal to the Quebec City nursing staff.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

The Great Need for Clinical Supervisors

Six years of war have created many problems in all fields of nursing. What we have done to meet these problems, and what we are doing now to stabilize nursing in wartime, will inevitably have a bearing upon the future character of nursing. This fact must be kept in mind in citing our postwar goals, and in planning for a greater scope and a better quality of nursing in the future.

The Survey of nursing completed in 1943, under the auspices of the Canadian Medical Procurement and Assignment Board, and the national registration, helped us to get our feet on the ground and to know where we stood in regard to many situations relating to nurses and nursing, and has laid the basis for the setting of objectives for postwar planning in Canada.

The shortage of bedside nurses, particularly in tuberculosis and psychiatric hospitals, was stated in the survey as a very serious situation. This situation apparently is becoming more serious as the war continues, and a plea was made in the last issue of the *Journal* that nurses come to the rescue. Unless there is some assurance that nurses will volunteer for service in these special hospitals, we are going to be ill prepared to meet the increased demand for bedside nurses which expanding hospitalization facilities in these services will create.

The time has come when nurses must assume greater responsibility to the public for nursing service. We must rise to the occasion now, and make ourselves known and felt by word and deed. The future of nursing in Canada is dependant upon the co-operative efforts of civilian nurses and those demobilized in meeting the nursing challenge of a postwar world.

Another shortage revealed in the survey, as reported by hospitals across Canada, was nurses with special preparation for teaching and supervisory positions. While every effort has been made, through the aid of scholarships, loans and government bursaries to prepare young nurses to fill these important posts, the supply is still not sufficient to meet wartime conditions, nor to deal with the tasks that lie ahead. While many schools of nursing at the present time are having difficulty in securing classroom instructors, the shortage of clinical supervisors seems even more serious, because their absence affects unfavourably, not only the educational program for students in the clinical services, but the care of patients as well.

Nurses in the Armed Forces have been sent, through the Department of National Defence, the official information (P.C. 331) regarding financial assistance for educational purposes upon demobilization. Their overseas experience should be a decided asset in undertaking further study and nursing work. A pamphlet has been prepared by your Committee on Postwar Planning, to be sent to all nurses in the Forces, containing information regarding courses in universities and hospitals, which should meet the need of demobilized nurses. Before this statement appears in the *Journal* the pamphlet will be on its way. Returns from the questionnaire indicate that many nurses now overseas intend to undertake some type of post-graduate study upon their return, and it is hoped that the field of *Clinical Supervision* may be an attraction. Certainly, if supervisors fulfil the function of modern supervision, as defined in democratic and scientific terms, they should not have a dull moment.

We are doing our best to increase the supply of hospital supervisors, through long and short term courses, but we look forward to the return of many experienced nurses, who may choose the field of clinical supervision as their future nursing work.

Interesting People

Edith Rainsford Dick, R.R.C., has returned from active service with the army overseas to become acting director of the Nurse Registration Branch of the Ontario Department of Health. Born and educated in Milton, Ontario, Miss Dick journeyed southward for her nursing training and graduated in 1930 from the Johns Hopkins Hospital in Baltimore. After serving for a year as head nurse in her alma mater, she took her certificate in public health nursing at the University of Toronto. For the next three years, Miss Dick was engaged in administration and supervision in the Ontario Mental Hospitals. From 1935 until her enlistment, she was inspector of Training Schools for Nurses in Ontario.

Karsh, Ottawa

EDITH DICK

In over four years service with the R.C.A.M.C. Miss Dick's experience in civilian hospitals won for her advancement and responsibility. At the time of her release from active service she held the rank of Major (Prin. Matron) and was on duty in France. She was awarded the Royal Red Cross, first class, in June, 1944. We are happy to welcome Miss Dick back to Canada and wish her well in her new position.

Dorothy Grace Riddell, who has recently been appointed inspector of Training Schools for Nurses, Nurse Registration Branch, Department of Health, Ontario, comes of pioneering stock. Her family came from Ireland in the early days and settled in Ontario. Miss Riddell was born in Saskatchewan, received her education in Manitoba, and taught public school in that province. She chose the Toronto General Hospital as her school of nursing and graduated there in 1931. After a brief experience in private and general duty, Miss Riddell took advantage of a scholarship she had received as a graduation prize and entered the University of Toronto for the course in hospital administration and teaching.

From 1933-37, she was a head nurse in the surgical division of the Toronto General Hospital. After two years as instructor at the McKellar Hospital, Fort William, Miss Riddell became assistant director of nurses at the Belleville General Hospital. She resigned from this position in 1943 to join the R.C.A.M.C. and saw active service in Canada and the United Kingdom, returning to Canada and civilian work early this year.

Miss Riddell has an interesting and unusual hobby. Just prior to the beginning of the war she spent nine months in England and on the continent where she learned the delicate cunning of the silversmith's craft. We hope she will find time among her new duties to pursue this intriguing avocation.

Kennedy, Toronto

DOROTHY RIDDELL

The appointment of **Margaret Hope Hewett** as assistant registrar of the Registered Nurses Association of British Columbia has recently been confirmed. Miss Hewett was born in China, of English parents. She attended high school in Victoria, B.C. and entered the School of Nursing of the Royal Jubilee Hospital whence she graduated in 1934. In 1942 Miss Hewett received her Bachelor of Arts degree from the University of British Columbia. Skating, tennis and badminton provide her with opportunities for vigorous activity. For the gentler arts Miss Hewett turns to art and is a member of the Art Gallery Association.

Alice Beyer Hunter has been welcomed back to assume the duties of superintendent of the Port Arthur General Hospital. Born in Kwangning, North China, Miss Hunter received her preliminary education at Belfast, North Ireland. Her high school work was taken in Havergal College, following which she completed the work for her B.A. degree at the University of Toronto. In 1927, Miss Hunter graduated from the Toronto General Hospital and for the next ten years was a head nurse in the surgical division there. In 1938, she became assistant superintendent at the General Hospital in Port Arthur. In 1941, when the Canadian Orthopedic Unit was organized by the Canadian Red Cross Society at the request of the Department of Health for Scotland, Miss Hunter was appointed matron. After nearly four years of service at Hairmyres Hospital, she has now returned to take over the administration of this Ontario hospital.

Mabel Hunter has recently retired from her position with the physiotherapy department at the Royal Victoria Hospital, Montreal, after nearly thirty years of faithful service there. A native of the province of Quebec, Miss Hunter graduated from the Royal Victoria Hospital in 1902. For ten years she engaged in private duty, then, in 1912 she undertook her training as a physiotherapist at the Orthopedic Institute in Philadelphia. In 1916 she returned to her own hospital to carry on this work and for many years has instructed the student nurses in the principles of massage. Perhaps Miss Hunter's greatest contribution was the work which she did with the returned soldiers after the first world war. Many of them have owed a debt of gratitude to her capable hands.

May Ewart, who retired from the Metropolitan Health Service, Vancouver, in February, 1945, was in the last class to be graduated by Miss Mary Agnes Snively from the Toronto General Hospital in 1910. After a year of private

duty nursing, she went to Vancouver and entered the Vancouver General Hospital as a staff nurse, and later served as a supervisor. In 1913, she was appointed as school nurse in Vancouver and, with three other nurses, pioneered in this work. In 1921, she organized the health services in the adjoining semi-urban Point Grey, covering many miles and serving many schools for eight years. When Vancouver and Point Grey amalgamated in 1929, Miss Ewart went to Kitsilano Junior High School Health Service. Here she carried on her good work for an ever-growing school population until February, 1945.

She is now retiring to her beautiful home in Caulfields, surrounded by her flowers and quietness.

Laura M. Sanders, after devoting the last twenty-four years to Child Health work in Vancouver, retired in September, 1944. Miss Sanders graduated from King's County Hospital in Brooklyn, New York, in 1916. After doing private duty nursing there for two years she came to Canada. She spent one year in Edmonton Military Hospital before going to Vancouver to join the staff of the Victorian Order of Nurses. She was in this work for only a year when she was appointed to the Vancouver City Health Department staff as a Child Welfare nurse. She became supervisor of this division in 1925 and, after the organization of the Metropolitan Health Service, was made consultant in Child Welfare to the Public Health Nursing Division.

Curing the "Focke-Wulf Jitters"

NANCY H. MACLENNAN

Editor's Note: The following abstract is published through the courtesy of the magazine, *Flying*. The article in its entirety may be found in their February, 1945 issue.

Instead of the traditional "rest cure", combat-weary airmen returned from war are now getting a "work cure". Hospitals once filled with long rows of beds occupied by inert and bored patients now hum with activity. Even the bedridden work. Doctors and patients alike testify that the work cure is one of the war's outstanding successes and shows excellent promise of revolutionizing many of our peacetime hospital methods.

The work cure is especially valuable in treating operational fatigue, unofficially known as "the Focke-Wulf jitters". Operational fatigue is the occupational disease of the combat flyer. It does not differ fundamentally from the nervous break-down of an overworked clerk who has a tyrannical boss or nagging wife". But there are differences.

"Each man has his flying efficiency curve and even the best will reach a point in that curve where he will break down himself or crack up his plane. Operational fatigue is an illness made of emotional and fatigue symptoms generally manifesting itself in a state of anxiety". It is not a true neurosis, but a reaction of normal people — otherwise sound pilots or crewmen — to abnormal situations. A psychoneurotic case is actually the reverse — an abnormal person reacting to a normal situation.

Operational fatigue knows no boundaries, favors no theater of war. It occurs more frequently among bomber crewmen than among fighter pilots because bomber pilot and crew must suppress individual impulses, stick at their stations and hold their plane in position, while the fighter pilot has comparative freedom of action. Bomber pilots and crewmen have been known to complain that they never get an opportunity to *fight!*

Operational fatigue shows most frequently during the first five missions — some airmen have "a low threshold of endurance". Another difficult period comes about two-thirds of the way through an operational tour when the accumulated effects of repeated stress may begin to tell and the flyer starts worrying about his luck running out before he gets leave.

Here's where the ounce of prevention has proven highly effective. Flight surgeons, noting fatigue signs, will pull a man off duty and send him to a rest camp away from combat for a week or so. Usually he comes back and successfully finishes his tour. The move is really a double safeguard. It saves the individual airman from a bad case of operational fatigue and it protects his fellow crewmen. Men suffering from operational fatigue often weaken the morale of other airmen and may even endanger the lives of those with whom they serve. Every precaution is taken to recognize such cases and to remove them from active duty. The job is done by the flight surgeon, who recommends the change to the commanding officer. Generally, the commanding officer follows flight surgeon recommendations.

This knowledge of operational fatigue tallies with the experiences of the airmen themselves in their influence upon one another and their individual willingness to admit their fears. The flyer has learned to recognize fear as a normal reaction and the group accepts his fears as long as he controls them. He is far better able to control his fears in combat if he understands that they cause operational fatigue.

When airmen do break, operational fatigue sets in. First symptoms are deterioration of flight performance, a feeling of being "washed out". Loneliness tension, indecision, restlessness, tremors, irritability, insomnia bring a corresponding loss of weight, appetite, ability to concentrate, confidence, and zest for flying. Severe cases have terrifying battle dreams, feel no ecstasy on returning from missions, suffer as from claustrophobia when flying in formation, often turn back because of imagined engine trouble. They complain of numbness and of feeling like "mechanical men".

Some men try to submerge their anxiety only to become convinced that their number is up. They worry incessantly about the state of their health. The cure is as dramatic as the cause. The job is to "unwind" the airman's psychological tension and to adjust his disturbing experiences to a rational place in his mental perspective.

Speaking generally, there are two basic steps in the treatment. The first is complete rest, insured, if necessary, by mild sedatives. The second is a mental purge, brought about by psychotherapy in which the psychiatrist interviews the patient and helps him to relieve his mind by drawing out suppressed battle fears and helping him "think his way out" of his mental conflicts.

Once the patient has recovered a normal viewpoint the services proceed to bring him back along the road of convalescence to active duty or to a normal civilian life. In this field has been applied the new "work cure" technique. If the patient is physically capable of it he is promptly encouraged to take an active part in games, therapeutic handiwork, or studies. He must do a certain amount of setting-up exercises daily and he must attend a daily discussion group on current events. Beyond this, he may choose from a larger number of useful training courses.

Such a program not only improves morale, but starts the soldier working and thinking in this field of interest and allows him to prepare himself for reassignment or, if this is impossible, to prepare for integration to civilian life.

It also works wonders in speeding recuperation. Men no longer have time to brood over personal problems or imaginary complaints. One hospital reported that as a result of the program the number of men needing sedatives to get to sleep was reduced from 44 per cent to 3 per cent. Jigsaw puzzles at bedside tables have been replaced by carburetors, tachometers, altimeters, and radio equipment. Demand for technical books at hospital libraries skyrocketed, detective story demands fell off. Classes in poster art develop pertinent posters for use at the hospital. Other patients learn to take and develop pictures, set type, run mimeograph machines, turn local publicity and develop a hospital newspaper.

Where the patient goes when pronounced cured adds to the high morale of those treated. They know that if at all possible they will be returned to their old job. Indications are that the program's scope will widen and, with the coming of peace, spread to civilian hospitals throughout the country, adding another effective technique in the eternal war against mental and physical disease and death.

R.C.A.M.C. Nursing Service

Some groups of Nursing Sisters have returned home to Canada after four or five years service overseas. Among them are some of the Sisters who were on the troop ship torpedoed in the Mediterranean in November, 1943.

The following is a list of changes, promotions and awards which have recently taken place in the R.C.A.M.C. Nursing Service.

P/M Elsie L. Riach, of No. 21 Canadian General Hospital serving with the 21st Army Group, has been mentioned in despatches.

P/M Helen G. Hewton has returned from the Italian Theatre of Operation and is now Principal Matron of No. 11 Canadian General Hospital in the United Kingdom.

P/M B. G. Herman, Principal Matron of the Mediterranean Theatre, has returned to her home in Canada on leave. She is replaced by *P/M Agnes J. Macleod* who was serving with the 21st Army Group.

P/M Mima MacLaren, of No. 10 Canadian General Hospital, has been appointed Principal Matron of the 21st Army Group. She is replaced by *P/M Moya Macdonald* of No. 7 Canadian General Hospital.

P/M Helen L. Wilson, of No. 11 Canadian General Hospital in the United Kingdom, has proceeded to the 21st Army Group in charge of No. 7 Canadian General Hospital.

P/M D. I. Riches, Principal Matron at C.M.H.Q., is on inspection of hospitals and nursing service in theatres of operation.

P/M F. G. Charlton, Principal Matron at N.D.H.Q., is on an inspection trip of hospitals and nursing services in Military Districts No. 12 and 13 and Pacific Command.

Health of the Army

Hospital admission records show there has been a striking decline in the incidence of many diseases in this war compared with the first World War, Major General George F. Lull, U.S.A., Deputy Surgeon General of the Army, told the International College of Surgeons which met at Philadelphia in October. The pneumonia rate, he said, has dropped from 19.0 to 12.8, the measles rate from 23.8 to 5.8, mumps from 55.8 to 6.2, scarlet fever from 2.8 to 1.6, meningococcic meningitis from 1.2 to 0.8, tuberculosis from 9.4 to 1.2 and venereal disease from 86.7 to 41.0. These figures represent annual hospital admission rates per thousand strength. Similarly the death rate from all diseases dropped from 14.1 in World War 1 to 0.6. The Army's influenza rate, which was 5.97 per one thousand in World War I, has become negligible, being less than one per one hundred thousand strength.

Office of the Surgeon General
Technical Information Division
Washington, D. C.

STUDENT NURSES PAGE

General Care of Laryngeal Diphtheria when a Tracheotomy is Performed

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Recently I had the experience of taking part in the nursing care of five cases of laryngeal diphtheria. These cases were children, only one of whom had had her tonsils removed; none had been immunized and all gave a common history of having had sore throats for five to seven days.

On admission to the hospital these children presented a grave picture. In each the membrane was so extensive that the breathing was obstructed. Retraction of the chest is typical of this type of diphtheria. It is marked by laboured, embarrassed breathing with the sternum drawn in deeply, as well as the soft tissues which are seemingly sucked in between the ribs, giving the thorax the general appearance of a skeleton. At times the breathing is stertorous. The colour is usually very cyanotic, and the patient exceedingly restless. In one of these cases the patient was in a semiconscious state when admitted.

On admission we gave a very large dose of antitoxin, from 100,000 to 150,000 units. The cardinal things to be remembered in the care of any case of diphtheria are rest and antitoxin. These cases were so far advanced that the doctor did not attempt an intubation, which is the insertion of a hard rubber tube through the mouth into the larynx through which the patient breathes, but immediately prepared for a tracheotomy. A tracheotomy is a vertical incision into the trachea and the insertion of a double tracheotomy tube — the patient breathes through this tube instead of through the nose and throat.

We had five tracheotomies in less than two months, and of these we lost only one. In this instance, we were at a definite disadvantage from the beginning, since the child was in very poor physical condition, and did not have the stamina that is so essential. I was assigned to accompany one of the patients to the operating room, and was able to see the operation performed. It was amazing to see the relief the patient obtained as soon as the incision was made into the trachea. The mucopurulent discharge simply bubbled up and could be easily removed with suction.

In nursing these patients the important thing was to have everything close at hand. One must know where to find each article at a moment's notice. The bed was made similar to an anesthetic bed, though the operation had been done under local anesthetic. It was routine to give these patients continuous steam inhalations, so the nozzle of the steam kettle was attached to the head of the bed, just out of the child's reach. We selected as large a bedside table as possible, and placed it close to the bed on the more convenient side. A medicine glass with hydrogen peroxide, a medicine dropper, and a solution bowl well filled with normal saline were kept on the table and covered with a sterile towel. These were used in connection with the suction. Also on the table were tracheotomy spreaders, tubes of the correct size, obturators or pilots to fit the tubes, a pair of scissors, probe, and sterile tape. These were all sterile and wrapped in a sterile towel, ready for immediate use. The tracheotomy tubes are silver curved tubes, about two inches long, and have an inner tube which may be removed to be cleaned. The tube is held in the incision by means of tapes tied around the neck.

It had been the practice of the doctor to require that these cases be nursed by a private duty nurse but due to the shortage of nurses this could not always be done. It was necessary for a nurse to be with the child at all times; in fact in a good many instances, it took two or three nurses to handle difficult situations. It made a great deal more work for the floor nurses, but it was excellent experience which was greatly appreciated.

The suction machine was placed close to the bed, usually right beside the table. We used a small catheter with the end cut off, connected by means of a glass irrigating tip to the usual suction tube; if the mucus was very thick we removed the catheter and used only the irrigating tip, which gave much stronger suction. We usually removed the inner tube before attempting to remove the secretions by suction, though at times it was not even necessary to do that. We found the suction was much more satisfactory if we instilled a few drops of normal saline or hydrogen peroxide in the tracheotomy tube before using the suction. It softened the secretions and made them more easily removed. If the catheter became plugged we placed the tip in the bowl of saline and allowed the suction to draw up a little of the solution. In this way the secretions were cleared from the catheter.

The inner tube had to be taken out and cleaned as often as every ten minutes in order to keep an unobstructed airway. We found a pipe cleaner and a running tap the most successful way to clean it. If the breathing was not relieved after removing the inner tube and using suction, it was necessary to summon aid immediately, have the tracheotomy tube removed and a fresh tube inserted. The doctor usually changed the complete equipment but at times the need was so urgent that the supervisor had to make the change. Many times we found the end of the outer tube completely occluded with hardened mucopurulent material or membrane.

An oxygen tank was kept beside the bed, and we made a practice of giving some oxygen for a few minutes after using the suction. In many cases it had to be given continuously. Instead of the usual face mask we used a small funnel which fitted very nicely over the tracheotomy tube.

The first two or three days after the operation the patient was given only liquids. The children soon got used to the tube in the trachea, and in very short time had no difficulty in swallowing. As soon as the breathing improved sufficiently the patient was able to take soft foods. We added a heaping teaspoon of glucose D to each glass of fruit juices and milk.

Diluted spirits frumenti with a little glucose was given as a mild sedative with fairly good effect. For restlessness we gave nembutal, grains a half per rectum, or if the respirations were fairly good a small dose of morphine was given. In almost every case the patients were given a small dose of sulfathiazole every four hours, for a few days, as a precautionary measure against pneumonia. Since the air is breathed almost directly into the lungs and is not warmed and filtered as it is ordinarily pneumonia is always possible as a further complication.

If the child was well-behaved and did not move around too much, it was very handy to keep the catheter from the suction machine wrapped in a sterile towel on the pillow beside his head. Sometimes it was necessary to restrain the hands, but usually they realized that everything possible was being done to help them. We kept the opening of the tube covered with gauze at all times, at intervals using a piece of gauze moistened with saline. This helped to moisten the air that the child breathed.

Since the air expired through the tube was laden with particles of mucus, the nurse had to be especially careful to protect herself. When a patient coughed the secretions might be carried several feet in the air. Of course, the usual precautions with a case of diphtheria had to be taken and a gown and mask worn at all times.

The most critical period was from twenty-four to thirty-six hours after the antitoxin was given, and in many cases the crisis would occur about twenty-four hours after the operation was performed. At this time the membrane started to separate and it took very careful watching and nursing to keep the airway open. During this phase the pulse had to be watched very carefully, and often stimulants were necessary. The tendency seemed to be for the patient to work so hard breathing that the heart suffered under the strain.

We gave from 25 to 100 cc. of plasma intravenously each day for two or three days after the operation. The primary reason for giving the plasma was to help drain the fluid from the tissues into the blood stream, and thus lessen the edema of the tissues of the throat.

In one particular case, a little boy of three was admitted to the ward. He was a well-developed, well-nourished little fellow, but his condition was extremely serious. He had had a sore throat which had been mistaken for simple croup for several days, and so he had been given no antitoxin. His respirations were very laboured, there was considerable retraction of the chest, and his colour was very cyanotic. A tracheotomy was performed and his condition seemed to be slightly improved. About thirty-six hours after the operation, removal of the inner tube and suction failed to relieve the attacks of dyspnea and cyanosis. He had several severe cyanotic attacks which were eased by removing the complete tracheotomy tube and inserting a fresh one. After several of these attacks he became extremely cyanotic, unconscious, and ceased to breathe. The whole tracheotomy tube was removed, the suction catheter placed in the trachea, and artificial respiration administered. Coramine was given and oxygen was used continuously. When the suction catheter was removed a piece of tenacious muco-purulent membrane about two inches long and an inch wide was at the end. A fresh tracheotomy tube was inserted, he gasped and breathed, his colour returning to normal almost immediately. The child was then given a sedative and slept in long naps, completely exhausted. His respirations became almost normal, and he had no more spasms. The material withdrawn from the trachea became thin, watery mucus, and when the child became a little stronger he could eject it through the tube himself. In cases such as this we learned that the obstruction to breathing was nearly always found to be in the trachea at the end of the tube.

After the breathing returned to normal and the secretions diminished, usually from five to eight days, we closed the tube off for ten or fifteen minutes at intervals. We had several small pieces of wood made to fit the outer tube. These were sterilized, and inserted in the opening. The peg was inserted for longer periods each time, and finally the tube was corked for thirty-six hours. If this proved satisfactory, the tube was then removed, the incision dusted with sulfathiazole powder, and a sterile dressing applied.

The patient is not able to speak above a whisper until the tube is corked, and the voice will be husky for some time. It is surprising how many children fight against having the tube closed off, because it means that they have to learn to breathe all over again and they do not appreciate the effort.

After the tube has been in for five or six days there is a certain amount of danger of inflammation. As a result of the membrane peeling off, the trachea becomes larger and more normal in size, and allows the tube to move around. This will heal with scar tissue and cause a stenosis which would necessitate further surgery. For this reason it is important that the tube be removed as soon as possible.

The length of time required for the tracheotomy wound to heal varies from two or three days to three weeks, according to the individual and the size of the incision. After removal of the tube the child should have absolute bed rest, and a light diet for about five weeks. Before discharge from the hospital the patient must have the required three successive negative nose and throat cultures. Often it takes longer to secure these cultures than in an uncomplicated case of diphtheria.

Lieutenant Governor Opens New Hospital Wing

Culminating many months of planning and labor, the new North Wing of Grace Hospital, Windsor, Ontario, was officially opened January 17, 1945, by Lieutenant Governor Albert Matthews. Hundreds of citizens joined in the celebration and enjoyed their first view of the ultra-modern, three-storey building which has been designed chiefly for the care of obstetrical patients. Souvenirs in the form of a booklet of baby verses composed by Major Christian Chapman, each tied with pink and blue ribbons, were presented to the visitors.

Staff dining-room.

The top floor is composed of a two-bed admitting room; labour rooms, three in number, and attractively furnished; three well-equipped delivery rooms, including electrically heated cots and other elaborate equipment; a doctors' sitting room, shower and bedroom, where the doctor may rest while waiting cases; a most thoughtfully arranged fathers' room complete with pleasant furnishings and a radio, where the "daddies-to-be" may pace the floor or wait in comfortable suspense for the arrival of the young guest. There are also three, three-bed wards and two four-bed wards and an isolation unit. The special nurseries are divided into cubicles, four by four feet, encased in metal and glass. Only nurses are permitted near the babies, even the doctors not being allowed to enter the room. When a doctor examines a child of one of his patients, he will enter an adjoining room, "scrub up" and have the baby passed to him through a wicket. Visitors see the new babies only through a glass square. They request the baby desired through a speaking system. In this way it is expected infection will be reduced to a minimum. There are also special germicidal lamps. There are the usual working units of diet kitchen, completely fitted with monel metal sinks and

Lieut. Gov. Albert Matthews at the opening of the new hospital wing.

equipment and electric food carriers, etc. A dumb-waiter is also provided; also wash rooms, sterilizing rooms, utility rooms, etc.

A large cubicle nursery is provided on the second floor, as well as a specially constructed three-cubicle premature nursery and an isolation unit.

The ground floor is in two sections, seventeen semi-private beds being provided for surgical cases and the 'T' part of the floor reserved for nine private obstetrical patients with its own cubicles and working units.

All the rooms are beautifully furnished with dark maple furniture, the over-bed and bedside tables being topped with formica; the colour scheme is in a delightfully soft shade of green, venetian blinds and pretty draperies are used throughout, and the floor is covered with an attractive green and black asphalt tiling.

The basement houses the superintendent's, staff, and students' dining-room. "Daring but beautiful" was the comment of an interior decorator when he saw the colour scheme of the dining-rooms. Brigadier Brett's thought was to endeavour to have the nurses, who spend so many hours caring for the sick, forget all about it during the meal hours and she has achieved this to perfection. The staff dining-room is painted in coral with blue-topped tables and white leather chairs, large mirrors, interesting pictures, and pretty drapes. The students' dining-room is equally attractive in a lovely blue, with black-topped tables and red leather chairs and, in addition, mirrors, pictures and drapes.

A sitting room with double-decker restroom for night nurses on their hours off duty is also provided, along with wash rooms. An attractively furnished and well-stocked library is an added feature. This also includes a mobile container so that a large number of books may be taken through the hospital for the patients to make their own selection.

The accommodation is now increased to 262, including the cubicles and with the increased new facilities we are hoping to better serve the citizens of this community.

Institutes

Twenty-two registered Sister nurses from various parts of the Dominion attended the institute on ward administration at the University of Ottawa School of Nursing. The lectures centred around the following topics: modern trends in nursing; public relations and public education; the philosophy of education as applied to clinical supervision; the ward as the laboratory to the school of nursing; ward teaching; qualifications and qualities of the supervisor; efficiency rating of the students; the auxiliary worker; the supervisor and the graduate nurse; vocational guidance and the supervisor; the undiagnosed tuberculosis case in the general hospital; and fire hazards. Round tables were conducted in Professional Ethics, and Saving in Time and Supplies. Demonstrations were given at the Ottawa General Hospital in the pediatric, obstetrical, medical and surgical wards to exemplify the various types of ward teaching. At the Strathcona Hospital for Contagious Diseases a very interesting demonstration explained isolation technique in detail and was followed by a visit through the hospital.

When the busy week came to a close the Sisters, who had participated freely and enthusiastically in the discussion, were unanimous in concluding that the supervisor should be a well-prepared executive, experienced in her special field; that the ward situation provides much stimulation for practice which has a real purpose, for learning which will be retained, and for developing important attitudes and appreciation in the student.

Representative group at the Ottawa institute.

A three-day refresher course was recently held at the Institute of Public Health, University of Western Ontario through the Federal Government grant. There were forty public health nurses and sixty-five hospital nurses who attended from all parts of Western Ontario. The first day both groups attended a joint meeting. During the morning session, Dr. G. A. Wheable, inspector administrator, London Board of Education, spoke on "Basic Principles of Administration". In the afternoon Dr. C. A. Bright, Westminster Hospital, spoke on "The Pyschological Adjustment of the Returned Soldier". Following this was "The Post-war Period and Nursing" — discussions participated in by Dr. W. Sherwood Fox, president of the University, Helen Penhale, and Mildred Walker. For the remainder of the course, the group met in two sections. The public health section started with a round table discussion led by Mildred Walker on the topic "Program Planning in Public Health Nursing". Discussion was carried by Edna Moore, director, Public Health Nursing, Department of Health; Louise Steele, V.O.N., London; Edna MacIlveen, field work supervisor. "The Value and Use of the Volunteer" was discussed by Maisie Roger, executive secretary, London Council of Social Agencies. "Co-ordination of Services" was discussed by Mrs. Mabel Hatcher, epidemiologist, Ontario Department of Health, Venereal Disease Control.

The hospital and school of nursing section also had round table discussions led by Helen Penhale. The program was divided into: (a) The clinical period: Newer trends in therapeutics, Dr. H. Grant Skinner, instructor in pharmacology and therapeutics, Medical School, London; How should we interpret the term: "Supervision", Sister Marion, superintendent of nurses, St. Joseph's Hospital, London; Methods we have found to be most satisfactory in supervising students. (b) The preclinical period: Teaching the sciences, Dr. H. A. Deluca, instructor in bio-chemistry, Medical School, London; Correlating the sciences and the nursing arts, Gena Bamforth, instructor, Toronto East General Hospital. (c) What guidance does the inexperienced teacher-supervisor require?: the theoretical side of her preparation, Helen E. Penhale; the practical side of her preparation, Sister Ursula, superintendent of nurses, St. Joseph's School of Nursing, Hamilton.

Book Reviews

The Hospital Head Nurse, by Mary M. Wayland, A.M., R.N., R. Louise McManus, A.M., R.N., and Margene O. Faddis, A.M., R.N., 574 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1944. Price $3.50.

Reviewed by Gertrude Hall, General Secretary, Canadian Nurses Association.

Changes in the hospital and nursing school, some brought about by conditions in the world at large which drastically affected their programs, made a fairly complete revision of "The Hospital Head Nurse" advisable. The "spirit" which permeated the first edition, and which did so much to focus attention on the head nurse as the "king pin" in the hospital organization, has been happily retained in the revision.

In her introductory remarks Miss Isabel Stewart, who edited the revision, states "Probably the greatest single contribution that can be made to both the nursing service of the hospital and nursing school to-day is to strengthen this indispensable corps of junior officers, to equip its members with the guides and tools they so badly need, and to inspire them with a greater confidence in themselves and in their work". This is the main purpose of "The Hospital Head Nurse."

It is evident to anyone who has any aquaintance with the work of the head nurse that important social and scientific, as well as technical, problems are involved in it. One has to dig well below the surface and reach far beyond the range of the so-called practical aspects of the subject if she is to be successful in solving these problems and is to enjoy the richer satisfactions that the position holds. No book could possibly cover all the needed information, and especially all the basic principles, on which these solutions rest. Even the problems themselves cannot all be presented, but the reader can get some idea of their range, variety and importance from the headings and sub-headings of the different chapters.

Part I deals with the administrative functions of the head nurse and is applicable to those holding positions in hospitals with or without schools of nursing. The introductory chapter gives a general description of the position of the head nurse and what it calls for in the way of fundamental knowledge and abilities. Other new chapters in Part I deal with vitally important topics, such as basic management principles. These are clearly stated and defined, and will be welcomed by junior head nurses as a guide in the organization of their respective units.

Other topics included in Part I relate to common hospital hazards, accidents and principles of supervision as applied to the direction of both professional and non-professional personel in the head nurse unit. At a time when auxiliary nursing personnel is being used so extensively as a means of augmenting hospital nursing service requirements, this particular chapter has real meaning and value and is commended for study by all those responsible for the care of patients.

Additional techniques, especially in relation to the management of the nursing service, have been suggested, described and illustrated, and there is also an elaboration of the factors affecting care, including an outline of the newer method of calculating the average bedside nursing hours. Head nurses will find this chapter helpful in estimating the nursing personnel requirements for their respective units.

Part II has been completely re-written

to include new material and to show the newer emphasis upon the clinical education program, the student's responsibility for learning, and the head nurse's responsibility as clinical teacher for directing the student's progress in her unit.

Illustrations of a possible plan for the division of responsibility for teaching the disease conditions occurring in six medical and six surgical units in a large hospital, also include a clinical content and head nurse Teaching Plan. Emphasis has rightly been given to the importance and method of teaching patients.

Chapter XXV deals with the appraisal of nursing ability and recording of the student's experience and progress. The basis and methods of appraisal are clearly and carefully outlined and are commended for study by hospital and public health nurses. There are excellent suggestions for group activity on this much-needed subject.

Part III considers the satisfactions and opportunities for creative service and personal satisfactions inherent in the position of head nurse. Excellent and fairly extensive bibliographies are given at the end of each chapter.

This book could be read with profit and pleasure by all those interested and associated with nurses and nursing.

Medical Care of the Discharged Hospital Patient, by Frode Jensen, M.D., H. G. Weiskotten, M.D., and Margaret A. Thomas, M.A. 94 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1944. Price $1.00.

Reviewed by Edith Pringle, Inspector of Hospitals and Institutions, B.C.

This book outlines and reports upon an experimental study undertaken by the Syracuse University College of Medicine. There are new ideas clearly set out which give information and data regarding the relationships of the hospital, the doctor and the social worker to the patient as a person; a cautionary note is given against a tendency to stress disease rather than the patient suffering from disease. Realizing that the major emphasis in a medical care program should be placed upon the needs of the individual patient and that there are other features of the program that should be co-ordinated with these needs, the author has in the report shown how this was actually accomplished at the University Hospital.

The descriptive report tells of the manner in which the experiment was conducted, discusses the various problems met, and evaluates the results of the study. The purpose of the experiment was to provide a service as well as conduct a study. One purpose was to provide a particular kind of medical care that had been lacking. The study was undertaken to inquire into "The value of continuous medical care to patients, who are economically unable to employ a family doctor, by a competent physician who is familiar not alone with the patient's illnesses but also with the relevant emotional and social economic factors".

The appointment of an extra-mural resident on the medical staff of the University Hospital and of the College of Medicine was the first step, followed by arrangements for co-operative facilities for hospitalization, medication, diagnostic procedures and social case work in the local health and social agencies. There were 902 patients served during the experimental program of which 85 per cent were chronically ill and 15 per cent acutely ill. The volume of work necessitated the appointment of a full-time social investigator to provide social data for research purposes but the actual social case treatment was left to the hospital social service department staff and to public and private agencies. Chapter 4 deals with the Physician-Patient relationship and Chapter 5 with Medical Social Work. There are many case illustrations. Doctors and social workers will find this study easy to read, interesting, containing information of value to all those concerned with medical social problems arising between the hospital and the home.

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NEWS NOTES

ALBERTA

CALGARY:

The following officers were recently elected by the Calgary General Hospital Alumnae Association: honourary president, A. Hebert; honourary vice-president, J. Connal; honourary members, M. Moodie, A. Casey, N. Murphy; past president, Mrs. G. Macpherson; president, Mrs. A. McIntyre; vice-presidents, Mmes E. Hall, H. Holland, N/S L. Kautz, H. Fisher; recording secretary, Mrs. J. Eakin; corresponding secretary, Mrs. W. Kemp; treasurer, Mrs. W. Kirkpatrick; committee conveners: refreshments, Mrs. W. MacMillian; entertainment, Mrs. T. Hall; membership, Mrs. E. Connolly; ways & means, Mrs. A. McGraw; visiting, Mrs. C. Boyd; overseas nurses auxiliary, Mrs. T. Valentine; press, Mrs. C. Glover; additional members, Mmes T. O'Keefe, A. Hammill, Miss I. Robertson.

Our Ice Carnival was very successful, the net proceeds being $2504, 25 per cent of which we used for war efforts and 75 per cent for our hospital. We are sending two parcels a year to each of our thirty nurses now serving overseas. For one week each year we sponsor the Red Triangle Hostess Club for the armed forces. Our members are supporting the Red Cross blood donor clinic. Mrs. Parks has been doing the laboratory work for the clinic since it started, and we are very proud of her voluntary contribution.

BRITISH COLUMBIA

NEW WESTMINSTER:

Royal Columbian Hospital:

With the aim of setting up a bursary for graduates of the Royal Columbian Hospital, the Alumnae Association entertained at a St. Patrick's Day tea. Mrs. J. A. McDonald was the convener and Mrs. W. E. Gutteridge was in charge of refreshments, while the dining-room was looked after by Mrs. G. Brine and the program by Mrs. D. Matheson. The president, Mrs. C. M. Purvis, with Mrs. J. McDonald and C. E. Clarke, received the guests, and Mmes W. Mott, D. Trumbull, C. D. Peel, H. B. Thompson, R. E. Mitchell and T. Amy poured tea. Contributions were received by Mrs. G. Grieve, while in charge of the drawing were Mmes E. Jarvis and E. M. Phillips.

ROSSLAND:

A reorganization meeting of the Rossland Chapter, R.N.A.B.C. was held recently when the following officers were elected: president F. McLean; vice-president, Mrs. J. McAllister; secretary, Mrs. W. Stevens; treasurer, Mrs. R. Williamson; program convener, Mrs. R. Thompson; social convener, Mrs. K. Scatchard. Future plans of activity were discussed and a social hour followed, refreshments being served by Mrs. R. Morin, M. Klein, and O. Hengle.

TRAIL:

The following officers were recently elected by Trail Chapter, R.N.A.B.C.: president, Mrs. K. Gordon; vice-president, Bernice Quick; secretary, Betty Kirkpatrick; treasurer, Mrs. Betty Kennedy.

At a recent meeting the retiring president, Dorothy Paulin, gave an interesting resumé of social activities and work accomplished during the past year. In February Alice Wright, registrar of the R.N.A.B.C., paid us a visit on her tour of training schools, and cleared up many points regarding registration in wartime.

Vancouver General Hospital:

The annual banquet of the Alumnae Association was held recently when the guests of honour were the members of the graduating class of 1945. Classes from 1907 were represented among the 250 present.

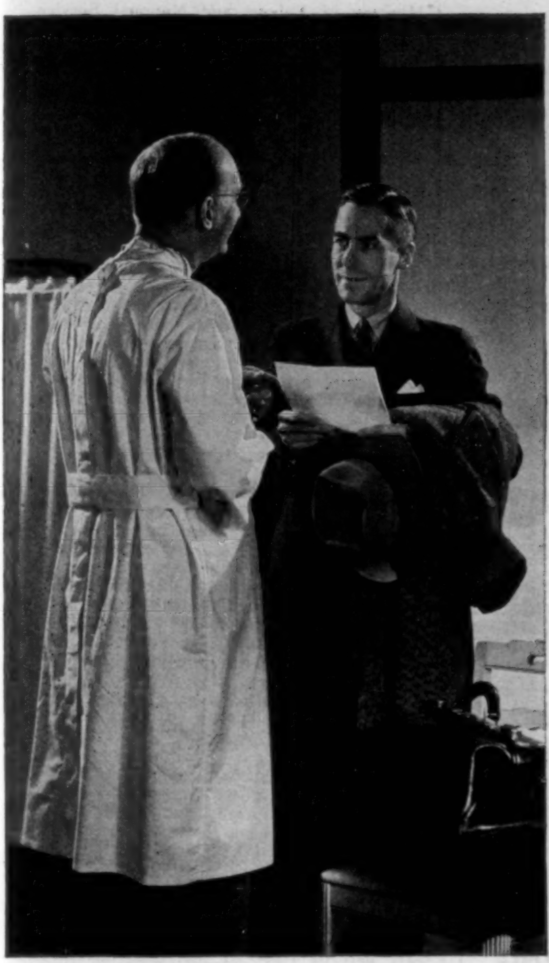
Following the toasts there was a clever skit by the senior students in nursing at U.B.C. It represented the dreadful dream of a student nurse conducting her first child welfare clinic. An excellent travelogue in colour, "South of the Border", was later presented. Credit for the arrangements is due to Mrs. Mary Mercer (Dunfield) and her committee.

ONTARIO

DISTRICT 4

HAMILTON:

At a well attended regular meeting of the Hamilton Chapter, District 4, R.N.A.O., with H. Snedden, the chairman, presiding, the guest speaker was Jeanette Merry, education officer of the Queen's Institute of District Nursing, London, England. Miss Merry conveyed the appreciation of the British nurses for the help given them during the blitz by the Canadian nurses. The Queen's nurses number 4600 in the British Isles, with an annual recruitment of 600 pre-war and 400 during the war. The



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THE RYERSON PRESS
TORONTO

Ministry of Labour and National Service was given power to call up nurses in certain age groups for nursing in civilian hospitals and services, thereby recruiting many married and part-time nurses. At the present time the government has under discussion the matter of pensions for British nurses. Miss Leleu moved a vote of thanks to Miss Merry for her interesting insight into life in wartime Britain. A social hour followed when Misses Chisholm and Scheifele presided at the tea table.

WELLAND:

As we no longer have a training school in Welland, we have reorganized our Alumnae Association and it is now called the Welland Graduate Nurses Association. This means that any registered nurse may now become a member. We have sixty-five members so far, including private duty, industrial, and general duty nurses. Last winter we conducted "A Country Fair" where we sold novelties, aprons, knitted goods, candy and home-made baking, which was all donated by the members and their friends. We also had two rooms of bingo and sold refreshments. We realized approximately $350. With our funds we are going to help the nurses registry, and keep our nurses alumnae ward in the hospital well supplied. We have donated $50 to the Red Cross, and also contributed to the I.O.D.E. for books for the services.

The nurses are co-operating splendidly and all seem very enthused. We try to have an interesting speaker at each meeting and have a social hour later.

DISTRICT 5

TORONTO:

The following report is submitted by Mary McLaughlin, president of the Inter-School Student Nurses' Association of Toronto.

The Inter-School Student Nurses' Association of Toronto had its beginning in the early part of 1937. At that time members of the Centralized Lecture Course Committee felt that there was a real need among the students for broader horizons and a more mutual relationship. Hence the idea of an inter-school organization was born. Although the seed originated with the higher powers it was to be planted, grown and bear fruit among the students themselves. It was to be essentially a student organization — giving scope to their imaginative and creative powers.

The opening of the season of 1944—45 found us weak and struggling. The absence of a constitution was readily rectified and then we started to enlarge and give more body to our year's program. An event for every month was planned and in some instances there were two. These were athletic and social in emphasis. In the realm of athletics we have participated only in tennis and basketball but in future we hope to add swimming to the list. At our social gatherings we have sought for the most part to dip into those spheres of culture outside our own profession.

Last Fall we were privileged to hear from Dr. E. J. Pratt, one of Canada's foremost poets. Lt. Col. A. C. Neill, on a brief tour of duty from England, brought us some of the highlights of wartime nursing in England, Africa, and Italy. The January meeting took the form of a musicale. In February we held our annual party and at our annual mass meeting Florence Emory spoke to us on "Opportunities in Nursing — Present and Future". A dinner, in honour of our nine graduating classes, closed our year in April.

Business meetings have been held each month to make the necessary arrangements for these gatherings. Our council consists of twenty-seven representatives — three from each school. From this council we elect an executive consisting of a president, vice-president, secretary, treasurer and conveners of social, athletic and publicity committees.

St. Michael's Hospital:

The quarterly meeting of St. Michael's Hospital Alumnae Association was held recently when the following officers were elected: president, M. Hunt; vice-presidents, M. Regan, L. Riley, M. McGarrell; treasurer, N. O'Connor; assist. treasurer, E. Cooper; recording secretary, M. Doherty; corresponding secretary, Mrs. Forrester; councillors, K. Boyle, D. Murphy, K. Meagher; conveners: active membership, L. Huck; associate membership, Mrs. M. Meaden; representatives to: public health, M. Tisdale; nursing education, G. Murphy; Local Council of Women, Mrs. Scully; press, E. Darrach; plan for hospital care, V. Murphy; editor, "The News", K. Boyle; assist. editor, Mrs. M. Neville. The Alumnae is very pleased to have Rev. Sr. M. Margaret, former honorary president, back with us in the same capacity after an absence of twelve years.

The guest speaker, Margaret Hunt (St. Michael's Hospital, 1932, and course in public health nursing, University of Toronto) gave an interesting account of her experiences overseas. Miss Hunt has recently returned after four and a half years service in England, North Africa, Sicily and Italy.

Special mention was given to Doreen Murphy for the successful project, instigated and convened by her, in aid of the scholarship fund. The post-graduate education of three students will be financed. Two of these nurses will be Alumnae members of two years standing and the other a member of the graduating class.

DISTRICT 8

The annual meeting of District 8,

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WINNIFRED GRIFFIN, Reg. N.

R.N.A.O., was held recently in Ottawa. The guest speaker was Mr. Walter S. Woods, Deputy Minister of Veterans Affairs. Mr. Woods gave an interesting talk on post-war rehabilitation plans, stressing the fact that the nursing profession offers a wide and varied field of opportunity for women serving in the armed forces.

The retiring secretary-treasurer, Joan Stock, stated that under the convenership of Sr. Madeleine of Jesus the membership has risen in the district to 703, an increase of 76 over the past year. The financial report showed that the expenditures of the association totalled $134.25, against a total income of $841.50, which was forwarded to Toronto. The bank balance for January amounted to $198.32. It was announced that W. Cooke, K. McIlraith, and J. Stock had been appointed to attend meetings of the post-war reconstruction committee of Ottawa-Hull.

The following officers were elected for the ensuing year: chairman, W. Cooke; vice-chairmen, M. Robertson, K. McIlraith; secretary-treasurer, Mrs. B. Taber; councillors, Sr. M. Evangeline, I. Allan, V. Belier, M. Hall, G. Moorhead, E. Graydon; chairmen: Pembroke Chapter, E. Cassidy; Cornwall Chapter, Sr. M. Mooney.

At a recent meeting of the Hospital and School of Nursing Section, District 8, R.N.A.O., the following officers were elected: chairman, M. Thompson; vice-chairman, Sr. Helen of Rome; secretary-treasurer, E. McIlraith.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

Madeleine Flander recently gave a refresher course in pediatrics at Charlottetown, P.E.I. Ella Vey, a former member of the staff is now at the Brome-Missisquoi-Perkins Hospital, Sweetsburg. Jeannette Soullière, who has recently taken a pediatric course in Detroit, is now on the staff. Hilda Nuttall has recently returned from a short course in ward teaching and administration in Toronto.

SASKATCHEWAN

MOOSE JAW CHAPTER:

At a recent meeting of the Moose Jaw Chapter, interesting letters were read from three nursing sisters serving overseas: Nursing Sisters Grace Canning, Wilhelmina H. Bergman, stationed at No. 21

C.G.H. and J. A. Havorke at No. 16. C.G.H. They were very grateful for the parcels sent at Christmas by the Chapter. Several letters of acknowledgement have also been received from N/S Meadows who is serving with Col. Young's unit overseas.

Peggy Ogilvy left Moose Jaw recently to take a position in Edmonton at the University Hospital. Prior to this, Miss Ogilvy was doing private duty nursing in Moose Jaw and assisting with the work of the Red Cross blood donor clinic, Mrs. Repaye will take over the duties of the sick and visiting committee which was vacated by Miss Ogilvy. The Chapter regrets the loss of two members, Mrs. Selvig and Mrs. Flack, their absence being felt keenly by the ways and means committee convened by Mrs. Helena Butler. Mrs. Selvig is now in Shaunavon and Mrs. Flack has accepted a position at the Weyburn General Hospital.

Kristie Jamieson was guest speaker at the meeting of the University Women's Club recently. Miss Jamieson had attended a conference on Venereal Disease control and gave her listeners the benefit of her experience in a well organized talk. Discussing the "problem" and the "program", the speaker gave information on the Four Sector front.

Mrs. Alta Tait reported recently a paid-up Chapter membership of 52.

The student nurses of the Moose Jaw General Hospital were "at home" recently to all graduate nurses of that school. The "entrance fee' for the graduates was a cup and saucer which will be used to equip the new snack bar in the residence. Betty Fisher acted as mistress of ceremonies for the evening and gave the roll call. A presentation was made to the three senior graduates present: Mrs. C. Barnes (1915); Mrs. J. Droppo (1916); Mrs. H. Gill (1917). A delightful evening was spent playing whist, bridge and bingo, with incidental music provided by Gwen Orrell. A lunch was later served by the students.

Marguerite Wilson, who has spent the past year in Bermuda, is visiting in Moose Jaw.

REGINA CHAPTER:

A very successful membership tea was recently held by the Chapter.

The Regina and Moose Jaw instructresses meet monthly at either Regina or Moose Jaw to "iron out" some of their daily problems and to help them raise their own standards of teaching.

Rev. Sr. Krause recently left the Regina Grey Nuns' Hospital. Rev. Sr. Murphy, who has been at St. Boniface, is the new superintendent of nurses. N/S's Harlton, Townsend and Moodie left the city recently for duty with the R.C.A.M.C.

SASKATOON CHAPTER:

At the annual meeting of the Saskatoon

Black Stockings Hard to Get?

Nurses-in-training, who must wear black, have stocking troubles too. The ideal solution is All-Fabric Tintex Dye. Dye any stockings BLACK — it's quick, easy! And All-Fabric Tintex is guaranteed! All-Fabric Tintex Dyes are sold everywhere!

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NUGGET
WHITE DRESSING

(the cake in the non-rust tin)

EXECUTIVE SECRETARY WANTED

Applications are invited for the combined position of (1) Executive Secretary & Registrar, Manitoba Association of Registered Nurses; and (2) Adviser to Schools of Nursing in Manitoba.

Applications should be submitted on or before June 15, 1945, and should provide the following data:
(1) Academic and professional qualifications; (2) Experience as a graduate nurse; (3) A certificate of health. Apply to:

Selections Committee, Manitoba Association of Registered Nurses,
214 Balmoral St., Winnipeg, Man.

USE

LAVORIS

For Effective Mouth Cleansing

Mouth care is a habit; Mouth health the result.

Chapter the following officers were elected for the coming year: president, M. Jarvis; vice-presidents, I. Mandin, L. deFaye; secretary, L. Willis; councillors, M. Chisholm, Rev. Sr. St. Croix, R. Smith, E. James, Mrs. C. Thompson, M. E. Grant. Twenty-two members were present and heard annual reports from the chairmen of the three sections, the registrar and treasurer, and conveners of the social and program and registry committees. It was noted that the Chapter is in an excellent financial position. Plans were made to hold the annual Vesper Service in St. John's Cathedral on May 13 in conjunction with the Nursing Sisters' Association.

Plans have also been made for a special meeting of nurses so that they may have the opportunity of meeting G. M. Hall, general secretary of the C. N. A., and M. E. Kerr, editor of *The Canadian Nurse*.

Joan Witney and Edna Larmour, formerly of the Saskatoon City Hospital staff, have joined the R.C.A.M.C. and are stationed in Eastern Canada. Both are graduates of the S. C. H. the former also holding the B. Sc. in Nursing from the University of Saskatchewan. Lucy D. Willis has accepted an appointment as instructor in nursing arts at the S.C.H., having been on the staff for some time as clinical instructor. Two recent appointments to the operating room staff of the S. C. H. are as follows: J. Campling has accepted an appointment as supervisor; A. Phillips has accepted a position on the general staff.

YORKTON CHAPTER:

Yorkton Chapter, District 4, has recently been approved by the Council of the S.R.N.A. as an authorized Chapter. It is the first Chapter to be formed in District 4. The following are the officers for 1945: president, Mrs. D. Logan; vice-president, Mrs. T. Stewart; secretary, M. S. Langstaff; treasurer, K. Francis; committee, Mmes J. Young, G. Sinclair.

The Chapter is particularly interested in contributing to some community enterprise. At present its members are helping with the making of dressings at the Yorkton Hospital. The Chapter is interested too in the newly-formed "Youth Organization" in Yorkton and is making inquiries as to what part they may take in assisting this worthwhile endeavour.

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WANTED

General Duty Nurses are required for an 80-bed general hospital in **Southern Ontario. Salary:** Minimum, $85; after six months, $90; after one year, $95. Full maintenance. Eight-hour day; six-day week. All graduate staff. Two weeks paid vacation. Two weeks sick leave. Free hospitalization. Apply in care of:

Box 3, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

Applications are invited for the position of **Provincial District Nurse** in the **Province of Alberta.** Districts located in rural areas. Cottage, water and fuel supplied by community. **Salary:** Minimum of $1500 per annum, plus Cost of Living Bonus. Sick leave. Annual vacation provided after one year's service. Apply to:

Miss Helen G. McArthur, Superintendent of Public Health Nurses,
218 Administration Bldg., Edmonton, Alta.

WANTED

General Duty Nurses are required for a modern 220-bed hospital. Eight-hour day; six-day week. Pleasant working conditions. Salary begins at $95 per month; increased to $ 100 after six months; plus meals and laundering of uniforms.

Opportunities for further advancement. Apply to:

Superintendent of Nurses, Jewish General Hospital, Montreal 26, P. Q.

WANTED

A Nurse is required for Staff work with the **Department of Health, St. Catharines, Ontario.** Certificate in Public Health Nursing necessary. The annual salary is $1400, or higher, depending on qualifications. Apply to:

Supervisor of Nursing, Department of Public Health, St. Catharines, Ont.

WANTED

An **Operating Room Supervisor,** with post-graduate experience, is required for the **Victoria Public Hospital.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Victoria Public Hospital, Fredericton, N.B.

WANTED

Applications are invited for the positions of **Assistant Night Supervisor, Obstetrical Night Supervisor,** and **Medical Supervisor** in a 200-bed hospital with a School of Nursing. Apply in care of:

Box 4, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

An **Operating Room Supervisor** and a **Dietitian** are required for the **Glace Bay General Hospital.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

Vancouver General Hospital desires applications from **Registered Nurses for General Duty.** State in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. **Salary:** $95 per month, living out, plus $19.92 cost of living bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. One month vacation each year with pay. **Note:** The Hospital can obtain exemption for accommodation from Emergency Shelter Administration. The nurse is not exempt, excepting through employ of Hospital. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital,
Vancouver, B. C.

WANTED

General Duty Nurses, registered or graduates, are required for the **Lady Minto Hospital.** The salary is $90 and $80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital, Cochrane, Ont.

WANTED

Applications are invited **immediately** for **Staff positions** with the **Department of Public Health and Welfare, Halifax, Nova Scotia.** Apply, stating qualifications, in care of:

Supervisor of Nurses, Department of Public Health & Welfare,
c/o Dalhousie Clinic Bldg., Halifax, N.S.

WANTED

An **Instructor of Nurses** is required for the **Prince Edward Island Hospital.** The position is open **September 1, 1945.** The salary is $100 per month, with full maintenance. Apply to:

Superintendent, P.E.I. Hospital, Charlottetown, P.E.I.

WANTED

Graduate Nurses, Instructress of Nurses, and a **Dietitian** are urgently required for the **Highland View Hospital** in **Amherst.** Apply to:

Highland View Hospital, Amherst, Nova Scotia.

WANTED

A Night Supervisor and **Night Assistant** are required for the **Cornwall General Hospital** of 75 beds. 6 night week; alternating week 5½; 3 hours off duty other nights. Apply, stating experience and qualifications, to:

H. C. Wilson, Supt., Cornwall General Hospital, Cornwall, Ont.

WANTED

A Registered Nurse is required as **Night Supervisor;** three Registered nurses are also required for **General Staff Duty.** Eight-hour day and six-day week, with full maintenance. Apply, stating salary expected, to:

Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit,
Montreal 25, P. Q.

WANTED

A qualified **Instructress** and a **Surgical Supervisor** are required **immediately** for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, General & Marine Hospital, Owen Sound, Ont.

WANTED

A Science and Practical Arts Instructor is required for the **Victoria Hospital, Prince Albert, Saskatchewan, for September 1, 1945.** The salary is **$150** per month, with full maintenance. Four weeks vacation and four weeks sick leave with pay each year. Apply, stating particulars, age, and qualifications, etc. to:

Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

General Duty Nurses are required **immediately** for the **Toronto Hospital for the Treatment of Tuberculosis.** Eight-hour day; six-day week; good living conditions. The salary to start is $85 per month. Apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ont.

WANTED

Two Registered Nurses are required for permanent **Night Duty.** The salary is $90 per month, plus full maintenance. One full night off each week. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

An Assistant to the **Superintendent of Nurses** is required by the **Sherbrooke Hospital.** Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available **immediately.** Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

General Duty Nurses are **urgently** required for a 350-bed **Tuberculosis Hospital.** Forty-eight and a half hour week, with one full day off. The salary is **$100** per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

General Staff Nurses are required for the **Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal.** Forty-eight hour week. The **salary** is **$100** per month, plus meals and laundry. Apply to:

Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P.Q.